The Modern Hospital

MARCH 1957

Survey of Doctors' Offices in Hospitals

Circular Design for a Nursing Unit

How to Read a Blueprint—First of a Series

Liability for Acts of Interns and Residents

Training Program for Executive Housekeepers

Making the Hospital Fit the Patient

VALLEY PRESBYTERIAN HOSPITAL, VAN NUYS, CALIF. (Page 74)

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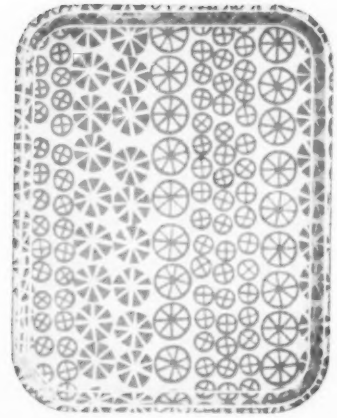

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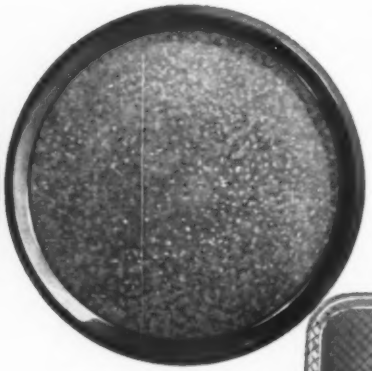

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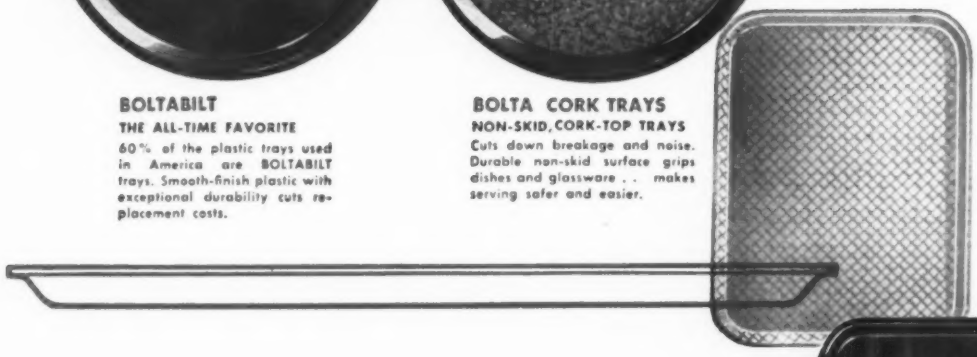

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Good Samaritan
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Kings County Hospital
Brooklyn, New York

Veterans Administration
Dayton, Ohio

Hinsdale San. and Hosp.
Hinsdale, Illinois

St. Mary's Mercy
Gary, Indiana

Lima Memorial
Lima, Ohio

Veterans Administration
Togus, Maine

Medical College
Charleston, S. C.

Marymount
Garfield Heights, Ohio

Baroness Erlanger
Chattanooga, Tenn.

Lewistown Hospital
Lewistown, Pa.

Mayview State
Mayview, Pa.

Middletown Hospital
Middletown, Ohio

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The Modern Hospital

MARCH 1957

VOLUME 88, NO. 3

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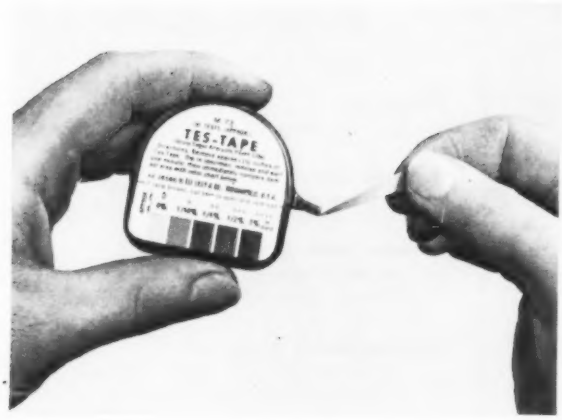
Published monthly and copyright © 1957 by The Modern Hospital Publishing Company, Inc., 919 North Michigan Avenue, Chicago 11, Ill., U.S.A. (Cable Address: Modital, Chicago.) Raymond P. Sloan, chairman, board of directors; Howard Barringer, president; Robert F. Marshall, executive vice president; Stanley R. Clague, vice president and secretary; H. Judd Payne, vice president; John P. McDermott, treasurer. Subscription price in U.S., U.S. Possessions and Canada $4 a year and $6 for two years; elsewhere, $6 a year and $10 for two years. Single copies, 50 cents; back copies $1. Member, Audit Bureau of Circulations, Magazine Publishers' Association. Entered as second-class matter, Oct. 1, 1918, at the post office at Chicago, Ill., under the act of March 3, 1879. Printed in U.S.A.



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AMONG THE AUTHORS


Dr. A .M. Burgess


M. Lucia Eagan

The value of oxygen therapy by tent was questioned by **Dr. Alex M. Burgess** and his co-author **M. Lucia Eagan,** after experience in checking oxygen use in some hospitals led them to believe that this form of therapy was often inefficient and expensive. At Newport Hospital, Newport, R.I., where Dr. Burgess is director of medical education and consultant in medicine and Mrs. Eagen is a clinical instructor in the school of nursing, the figures on the use and expense of oxygen therapy seemed much more favorable. To check the accuracy of the records at Newport and to determine whether treatment methods should be changed, the authors made a study of 15 patients receiving oxygen therapy by tent during a period of eight weeks. Their conclusions are found on page 100.

Dr. Burgess is also director of professional education and consultant in medicine at Miriam Hospital, Providence, R.I., and serves as commissioner of the Joint Commission on Accreditation of Hospitals and national chairman of the National Committee for Resettlement of Foreign Physicians.

His associate, Mrs. Eagan, is a graduate of the Newport Hospital School of Nursing and attended New York University before entering the navy nurse corps.


Kathryn B. Slavin

When Albany Hospital, Albany, N.Y., was faced with staff problems resulting from changes in hospital policies, nursing procedures and administrative routines, and from considerable turnover among nurses and auxiliary workers, something had to be done. The result was the appointment of **Kathryn B. Slavin,** assistant supervisor of nursing service, to plan a program of staff education. The general and specific objectives of the program, the methods used, and the results achieved at Albany Hospital are discussed by Mrs. Slavin on page 85. The author is a graduate of the University of Minnesota School of Nursing and has a degree in nursing education from New York University. She worked as a psychiatric nurse at Queens Hospital, Honolulu, T.H., and served in the army nurse corps and with the Veterans Administration, Northport, Long Island, N.Y. Last August, Mrs. Slavin left Albany Hospital to take the position of director of the school of nursing and nursing service at Nathan Littauer Hospital, Gloversville, N.Y.

The legal liability of a hospital for the acts of its residents and interns usually depends upon whether they were acting as servants of the hospital. On page 81 **Albert Woodruff Gray** cites specific cases of medical negligence and discusses the facts on which the court ruling in each case was based. A graduate of Yale University and New York University Law School, Mr. Gray has acted as legal adviser for a well known advertising agency and as an editorial writer for Prentice-Hall Publishing Company, New York. He is the author of "Family Legal Adviser" and "Purchase Law Manual" and a contributor to several magazines.

Also in this issue is a study of the advantages and disadvantages of establishing doctors' offices in connection with a hospital, conducted by **C. Rufus Rorem,** executive director of the Hospital Council of Philadelphia. Dr. Rorem's article (p. 55) is accompanied by comments from several administrators and doctors.

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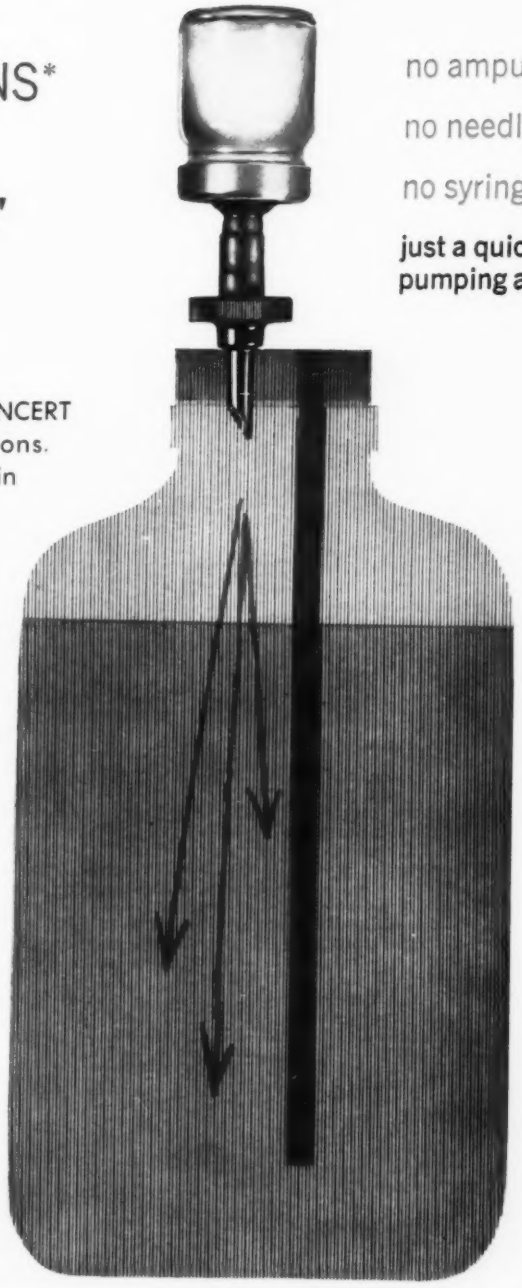

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READER OPINION

Likes Tale of Two Houses

Sirs:

I don't know who wrote the editorial, "Tale of Two Houses," on page 50 of the January 1957 issue of The MODERN HOSPITAL.

I do want to say I think it is excellent. I believe there is much that as administrators in our association relationships we can learn from the doctors. Personally, I have for the last several years listened to the American Hospital Association house of delegates in session, and the spectator turnout has been pitiful. It must be a knotty problem for the program committee on the national level to bring in a presentation that is interesting and informative to an administrator who comes from a 50 bed rural hospital and sits beside the administrator from a 450 bed urban institution. Logically it follows to me that more emphasis should be placed on state and regional meetings where kindred problems can be discussed on a level where group participation is at a maximum.

In addition, I think the American Hospital Association top organization might take a cue from the American Medical Association top organization in the American Medical Association's method in which reports and resolutions are referred to a committee in which open hearings are conducted and interested parties can appear before these open hearings to present relevant facts. This is the way state and national governments work, and I believe the idea carries a lot of merit for serious consideration by the American Hospital Association.

Harry E. Panhorst
Associate Director

Barnes Hospital
St. Louis

Thanks Hospital Suppliers

Sirs:

It seems that hospital suppliers are often somewhat akin to a tin can on a rural fence post—fair game for all who are passing by to take a pot shot at them.

During the past few weeks, since I have been administrator of Community Hospital of Evanston, I have been happily impressed with the ethics, helpfulness and service of the hospital supply houses that service this hospital.

Like any administrator, I was on the "qui vive" for the overzealous high pressure salesmen when I first arrived at the hospital. I have found, however, that in most instances the supplier was just as anxious to protect the hospital and the patient as was I.

In support of this view I cite these few brief examples:

More often than I can remember, salesmen, when asked, have told us that a smaller order than we anticipated placing could be safely placed since they could make deliveries within a few hours. This allows us to carry small stocks and has eliminated unnecessary over-extension of our admittedly limited financial resources. Here we find the paradox of the salesmen telling us that 2 dozen of "X" is what we should buy instead of the 4 dozen of "X" requested by the department head! This is certainly contrary to the usual picture painted of hospital sales-

men as zealous "order-takers" anxious only to obtain the largest possible order at the highest possible price.

Another example—and the climax which has prompted me to put these thoughts on paper—occurred just the other day. To comply with state regulations, we were forced to shut down two of our boilers for cleaning and inspection. We were faced with the problem of providing sterile hot water for emergency surgery during the six-day interval involved. The department heads involved recommended purchase of approximately $400 of additional equipment for the hospital in order to provide sterile hot water for surgery during the boiler shutdown. Four hundred dollars is a large sum in most hospitals. It is a particularly large sum for this one.

We took the problem to one of the nation's large supply houses because it carried the additional equipment I had been asked to procure. The supply house—in a matter of minutes—contacted the sterilizer company which had installed and serviced our sterilizers. They in turn contacted me and—without being asked—came to the hospital (within the hour) and instructed our staff in how to meet this problem by purchasing about $10 of incidental supplies. Since the sterilizer company did not, themselves, carry the supplies needed, they phoned the company that did and arranged for a special shipment. Three firms assisted us—through several phone calls—a personal visit (no charge) and a special delivery shipment. Total cost to the hospital $10! I cannot estimate the cost to the suppliers, but I do know two of them received no compensation in orders and the third firm received only a $10 order.

Perhaps immediately after World War II the hospital supply field was surfeited with salesmen out for a "fast buck" uninformed about hospital procedures—interested only in getting in and getting out.

It seems to me at this writing that those salesmen have been replaced by a group of professionally minded service representatives who can be and have been very helpful.

I hope this hospital is not unusually fortunate in its experiences. I have no reason now to think that it is.

Evidently there is a new era in hospital sales managers—a new awareness of the values of service, helpfulness and integrity and service to patients. It is fitting, I think, that the hospital field give credit where credit is due—to the enlightened hospital supply salesmen.

Howard F. Cook
Administrator
Community Hospital of Evanston
Evanston, Ill.

Identification Error

Sirs:

Perhaps some hospital administrators and OB supervisors who read "System of Identifying Infants Called Unfailing" in The MODERN HOSPITAL for November 1956 were unnecessarily disturbed by an omission which undoubtedly escaped your attention.

We refer to omission of the words "or number" in the author's indirect quotation from an editorial in the September 22 *Journal of the A.M.A.* Readers who had not seen the *Journal* editorial may have been led to believe that it set up fingerprinting of the mother on bands to be worn by her and her baby as a requirement for the correlated mother-baby identification. Those who had read the editorial undoubtedly recalled that the *A.M.A. Journal* recommends "some correlation," but does not limit the possible

methods to fingerprinting—nor, necessarily, to the correlated numbering system which is the established method in wide use today.

In this connection, the *Journal* editorial said: "The identification items should show the mother's full name, date and time of birth, and some correlation with the mother, *such as her fingerprint or number.*" (italic mine.)

Your article quoted the *Journal* as recommending a procedure under which "each baby is given two identification bands in the delivery room," each band carrying "the mother's full name, date, time of birth, *as well as the mother's fingerprint.*" Obviously, the omission of the word "or" and the substitution of the words "as well as" amount to a gross misquote, changing completely the intent of the A.M.A. recommendation.

How the error occurred is of no importance to us, but we cannot leave uncorrected an error that could bring embarrassment to the *A.M.A. Journal* and possibly discourage some administrators and OB supervisors considering mother-baby identification.

It would, quite obviously, be impractical to train OB staffs to make accurate comparison of fingerprints to verify identity.

Since only an expert with a magnifying glass can identify skin prints, a system of newborn identification which correlates infant and mother by means of a fingerprint alone is impractical in the rush of everyday hospital procedure.

On the other hand, anyone, including the mother herself, can check *correlated numbers* on the baby's band to make identification certain. Our own OB Ident-A-Band is manufactured with correlated numbers sealed into each set of mother-baby bands, and the system has established itself as "unfailing" in preventing mixups of several million newborn babies and their mothers over a period of six years.

Our firsthand knowledge of the success of our own system which conforms with suggestions contained in "Routines and Procedures of Identifying Newborn," published by the American Academy of Pediatrics—and also with the recommendation made by the *Journal of the American Medical Association* in the editorial earlier referred to—forces us to submit this correction of your article on "unfailing" identification of newborn.

I shall be glad to send our reprint of the American Society of Pediatrics "Routines and Procedures of Identifying Newborn" to readers who write me.

John Dickinson Schneider
President
Franklin C. Hollister Company
Chicago

Proper Use of "Conductive"

Sirs:

I have an editorial suggestion that you and your staff may wish to consider. It concerns the word "conductive" as applicable to operating room flooring and floor maintenance materials. In conversations and correspondence with our salesmen and sales supervisors and in advertisements in hospital publications, the word apparently has different degrees of meaning among people in the hospital field.

I interpret conductive floors, conductive waxes and conductive finishes to mean they possess an inherent or built-in ability actually to conduct electricity. However, a great many hospital people and hospital suppliers apply the word "conductive" to many materials just so long as they do not decrease (or only slightly decrease) conductivity.

A cleaner, wax or floor coating which when applied to a nonconductive floor makes that floor conductive is a true conductive product. On the other hand, a cleaner, wax or coating which when applied to a conductive floor does not interfere (or only slightly interferes) with conductivity is not a conductive product. Yet many hospital officials and hospital suppliers apparently believe that both types merit the description of conductive.

I anticipate a justifiable reaction on your part that this is a pretty minor matter of semantics. I would agree except that floor conductivity is occasionally a question of life and death in the operating room. I believe that your editorial department should study, discuss and consider the possible merit of a clarifying article on the subject. Perhaps I am overemphasizing a very minor point. However, I am personally interested in having as few operating room explosions in hospitals as possible, and believe that a lack of agreement on what is a conductive product and what isn't may well be instrumental in causing an accident.

William H. Marsden
Vestal, Incorporated
St. Louis

at Rhode Island Hospital...

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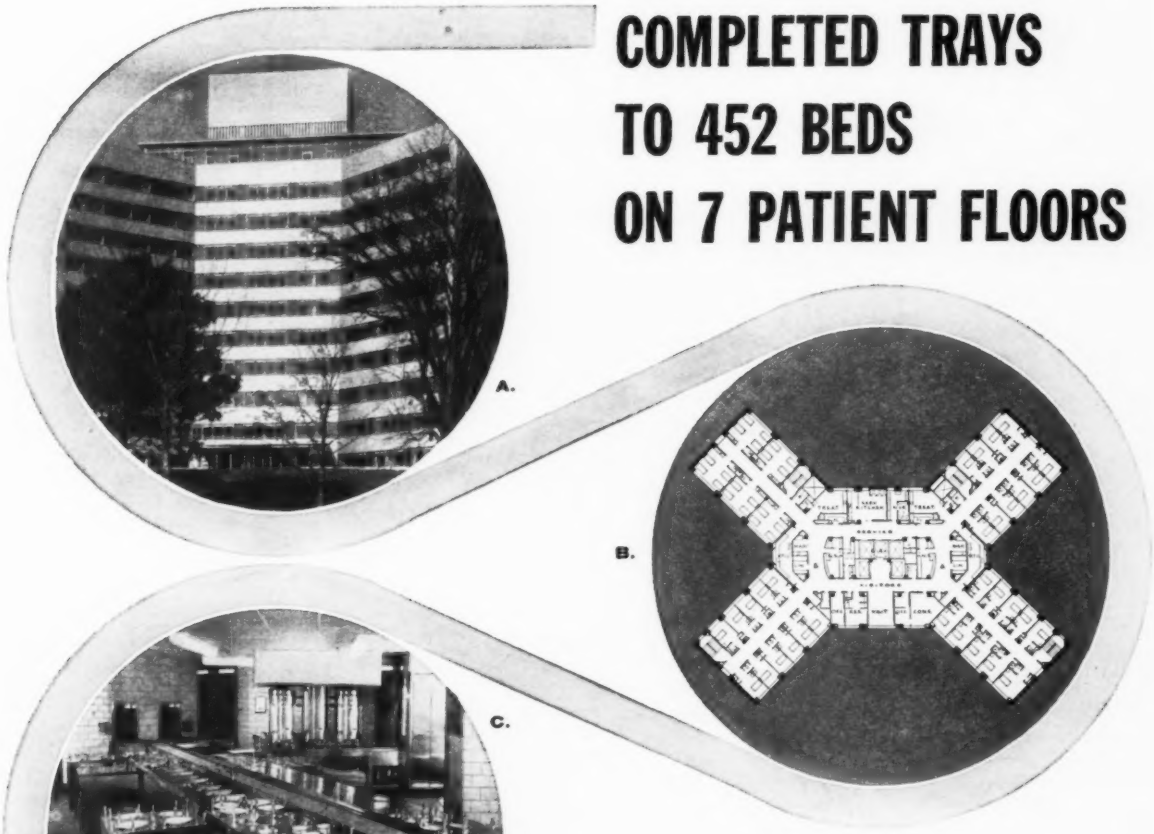

A. Exterior of the new Rhode Island Hospital Main Building, Providence, R. I.

B. Typical floor plan in the 452-bed hospital.

C. Belt line service to patients. All foods are delivered directly to this belt for make-up and delivery through trayveyor. Cold foods are stored in cooled units under counter until needed. Trays are stored in mobile Lowerators at beginning of belt. Heated dish Lowerators are stored in fixed position on top of counter.

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How Much Should Be Spent on the Public Relations Program?

By GORDON DAVIS


Gordon Davis

WHERE can I get the money for a public relations program, and how much will the program cost?

Good questions, these, and part of the answer is: Don't begin by feeling guilty about it.

In the health field, surrounded as it is by traditions of self-effacing, humanitarian service, there still lingers a faint feeling that public relations activity is somehow commercial or self-seeking.

The idea is an odd one. The only thing that a nonprofit agency has to "sell" is nonprofit service. Its public relations activities should be directed wholly at building better public understanding of its service, therefore and thereby contributing to its greater public usefulness.

In the case of a hospital, for instance, the community it serves invests a great deal of money in the hospital's physical plant. Its patients in turn spend a great deal more to support its services.

An adequate, organized program to interpret the services and continuing needs of this community investment can scarcely be considered anything less than a basic obligation.

This, then, is how you get the money for a public relations program: By beginning with the assumption that it is an essential service. Surely it is as important to satisfy the human hunger for understanding and enlightenment as it is to satisfy the human desire for physical health.

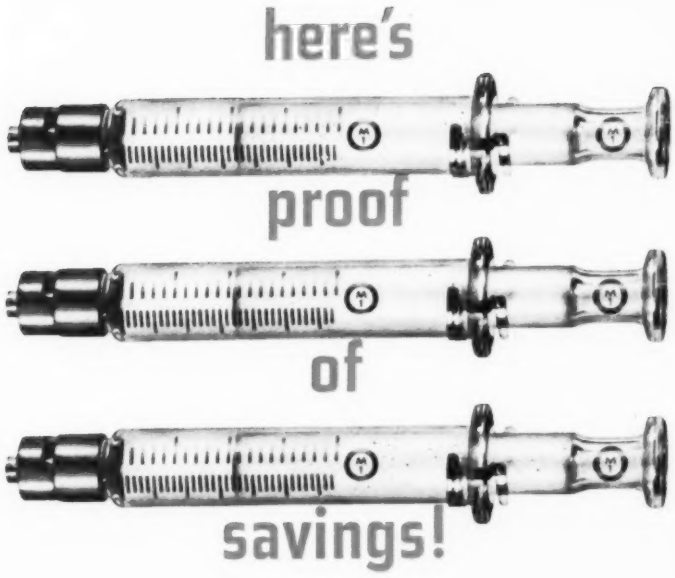
In actual practice, all budgets offer a choice. You decide what it is important for you to buy with the money you have or expect to have. The nonessentials you trim off or postpone. If public relations is not in the essential category, it is because the executive responsible for budget making has elected its omission.

How much should be spent on public relations? The nature of the program determines the amount of the expenditure, and the program itself should be evolved out of experience. A modest beginning initiated thoughtfully will in due time build into experience indicating its own proper scope and financial requirements.

Moreover, every public organization or institution already spends money on public relations, whether or not the expenditures are so earmarked. Literature, mailing expense, publications, telephone information service, time spent on speeches—all these and many related efforts may come under the public relations heading. It is sound economy to organize and integrate these activities so that they serve measured objectives and produce maximum results.

The problem of public relations is not truly one of money but of getting started. Money is but one of many reasons for deferring action on a matter which has not been forced to executive decision.

When the basic decision affecting public relations has been made, when the correct functions of public relations and the logic of their organization are truly understood, the answers to collateral questions have a way of working themselves out.



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B — 237 beds, 6,739 admissions	52 weeks	25.0	10.0	15.0	60.0
C — 250 beds, 10,387 admissions	52 weeks	26.57	17.557	9.013	33.9
D — 375 beds, 8,703 admissions	45 weeks	38.07	17.91	20.16	53.0
E — 520 beds, 9,086 admissions	45 weeks	38.92	22.177	16.743	43.0

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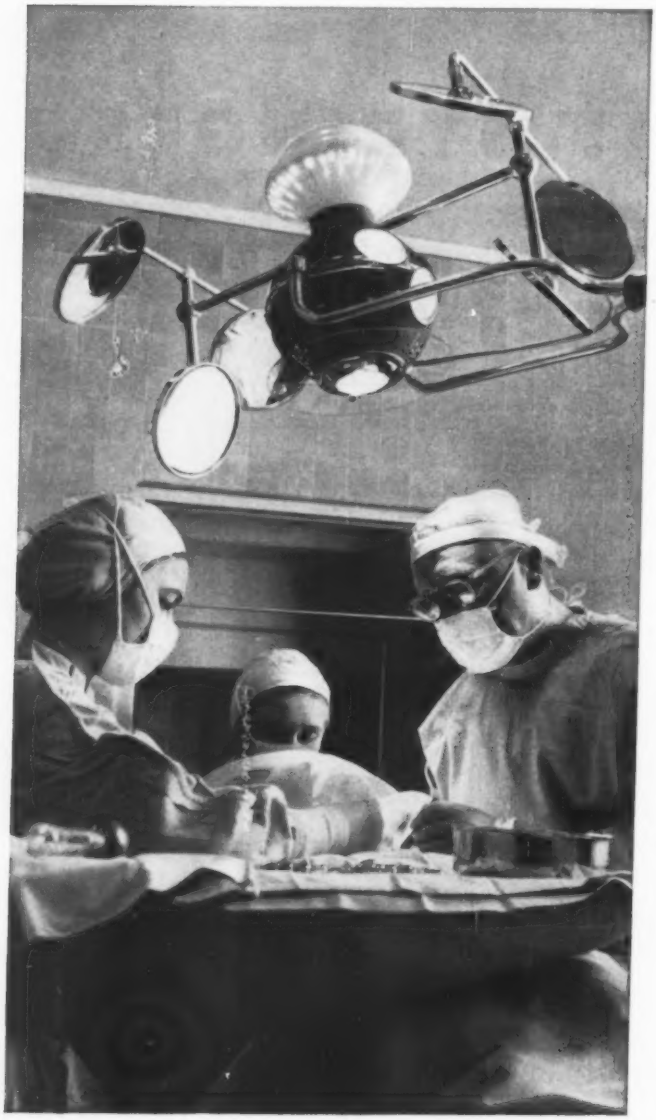

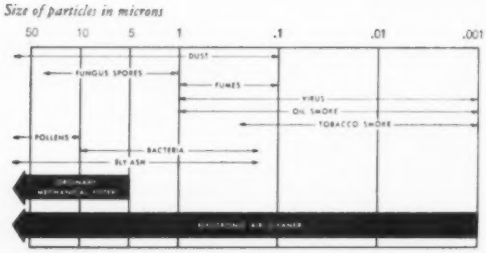

HERE'S PROOF—

As shown above, common air-borne contaminants range in size from 50 to .001 microns. In this area are the major causes of many respiratory ills and much soiling. Notice the scope of protection offered by the Honeywell Electronic Air Cleaner. It removes not only the large coarse particles, but the microscopic carriers of dirt and disease, as well. For all practical purposes, the ordinary mechanical air filter removes very little under 5 microns in size.

Now Honeywell, world leader in automatic controls, makes available a major new contribution toward complete hospital sanitation—an air filtration system having a bacterial and viral arrestance of 90% or more.*

With Honeywell's new Electronic Air Cleaner, both patients and personnel enjoy the added protection of an almost germ-free atmosphere.

This sterilized atmosphere is a truly new kind of safeguard not possible with ordinary mechanical air filters that miss many sub-microscopic carriers of disease. It means drastically reduced cleaning and redecorating costs, too.

These benefits are ample reason for you to consider a Honeywell Electronic Air Cleaner for your hospital. For details, see your architect or engineer. Or call your local Honeywell office. Address inquiries to Dept. MH-3-94, Minneapolis 8, Minn.

**According to studies made by U. S. Bacterial Warfare Center, Camp Detrick, U.S.A.*

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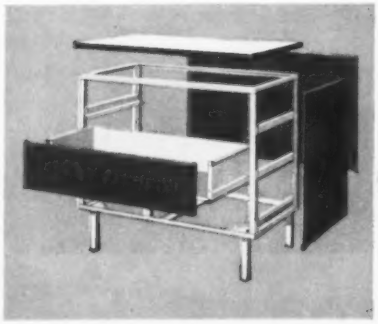
Honeywell

First in Controls

112 Offices across the nation

Introducing a stimulating new concept

The Beauty of Wood...The Strength of Steel



"Skyscraper" inner frame of steel. Individually removable wood panels. Beautiful, functional, economical. Write for complete information.

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ROYAL METAL MANUFACTURING COMPANY
1 Park Avenue, New York 16, N. Y., Dept. 8-D

"Here's how Gold Bond says *Sh-h-h*" in Millard Fillmore hospital

ACOUSTIMETAL

Buffalo's Millard Fillmore Hospital knows that quiet is important in speeding patients' recovery *and* in maintaining hospital efficiency. That's why this hospital's new wing has Gold Bond acoustical ceilings throughout.

In operating rooms like the delivery room shown at left, Gold Bond Acoustimetal ceiling units "swallow up" distracting noises. Acoustimetal's white, baked enamel surface may be easily sponged off to keep it "hospital clean"— it gives high light-reflection, too.

TRAVACOUSTIC

Gold Bond Travacoustic contributes quiet and distinctive beauty to ceilings in the hospital's corridors and lounge. Each tile is richly fissured to resemble Travertine stone.

Both Travacoustic and Acoustimetal are incombustible. And both may be repainted without loss of sound absorption.

For more information on quieting your hospital call your local Gold Bond Acoustical Contractor. He's listed in the Yellow Pages under "Acoustical Contractors". Or write National Gypsum Company, Dept. MH-37, Buffalo 2, New York.

ACOUSTICAL CEILINGS

NATIONAL GYPSUM COMPANY

Gold Bond
BUILDING PRODUCTS

of the hospital team!

ments. A nationwide network of over 500 supply depots insures prompt delivery and uninterrupted supply during every contingency.

Whether your hospital is large or small, Ohio Chemical services you with custom-designed oxygen delivery units tailored to meet your specific needs. Standard cylinders for use individually or in manifolds, plus a variety of bulk delivery units to feed oxygen into a pipeline system, are matched to your requirements.

Whenever consideration is being given to the piping of oxygen in existing or projected buildings, you can avail yourselves of another service provided by Ohio Chemical. Our engineering staff will assist, without obligation, the administrator, architect, contractor and others in the preparation of plans and specifications.

Ohio Chemical manufactures a comprehensive grouping of all necessary pipeline fixtures and equipment. Moreover, the Ohio line of end-use oxygen therapy apparatus and accessories offers a complete selection to meet the most exacting medical techniques. All of this equipment is serviced by factory-trained repair men who use only genuine replacement parts.

In addition, Ohio Chemical's research and development staff works with the medical profession not only to keep pace with present demands, but to anticipate the needs for improved apparatus.

The "Ohio" station wagon brings the personal service of a skilled representative within easy reach of your hospital

OHIO PRODUCTS

MEDICAL GASES • THERAPY OXYGEN
CENTRAL PIPELINE SYSTEMS
ANESTHESIA AND ANALGESIA APPARATUS
OXYGEN THERAPY AND RESUSCITATION EQUIPMENT
STERIL-BRITE FURNITURE • SURGICAL SUTURES AND NEEDLES
STILLE SURGICAL INSTRUMENTS

OTHER OHIO SERVICE AIDS

A wealth of helpful literature and audiovisual training material will be supplied without charge or obligation. This is supplemented by personal instruction and service where desired. **Only Ohio Chemical helps hospitals in so many ways.**

- ☐ Brochure on Ohio Chemical's **Complete** Therapy Oxygen Service
- ☐ Catalog of Central Pipeline Systems Equipment
- ☐ Catalog of Therapy Oxygen Apparatus and Accessories
- ☐ Catalog of Resuscitation Equipment
- ☐ Guide to hospital administrators in the billing of patients for oxygen therapy
- ☐ Inhalation Therapy Procedure Notes
- ☐ Directory of medical article reprints available from Ohio Chemical's library
- ☐ Brochure, "Safety In Hospitals"
- ☐ "Oxygen In Use" caution cards
- ☐ "Full and Empty" oxygen cylinder tags
- ☐ A 35 mm. sound and color filmstrip, "The Purpose and Techniques of Oxygen Therapy"
- ☐ A 35 mm. sound and color filmstrip, "Oxygen Therapy in Diseases of the Heart and Lung"
- ☐ The services of an oxygen therapy specialist as lecturer and demonstrator
- ☐ Assistance of our Oxygen Therapy Consultant in evaluating your inhalation therapy program

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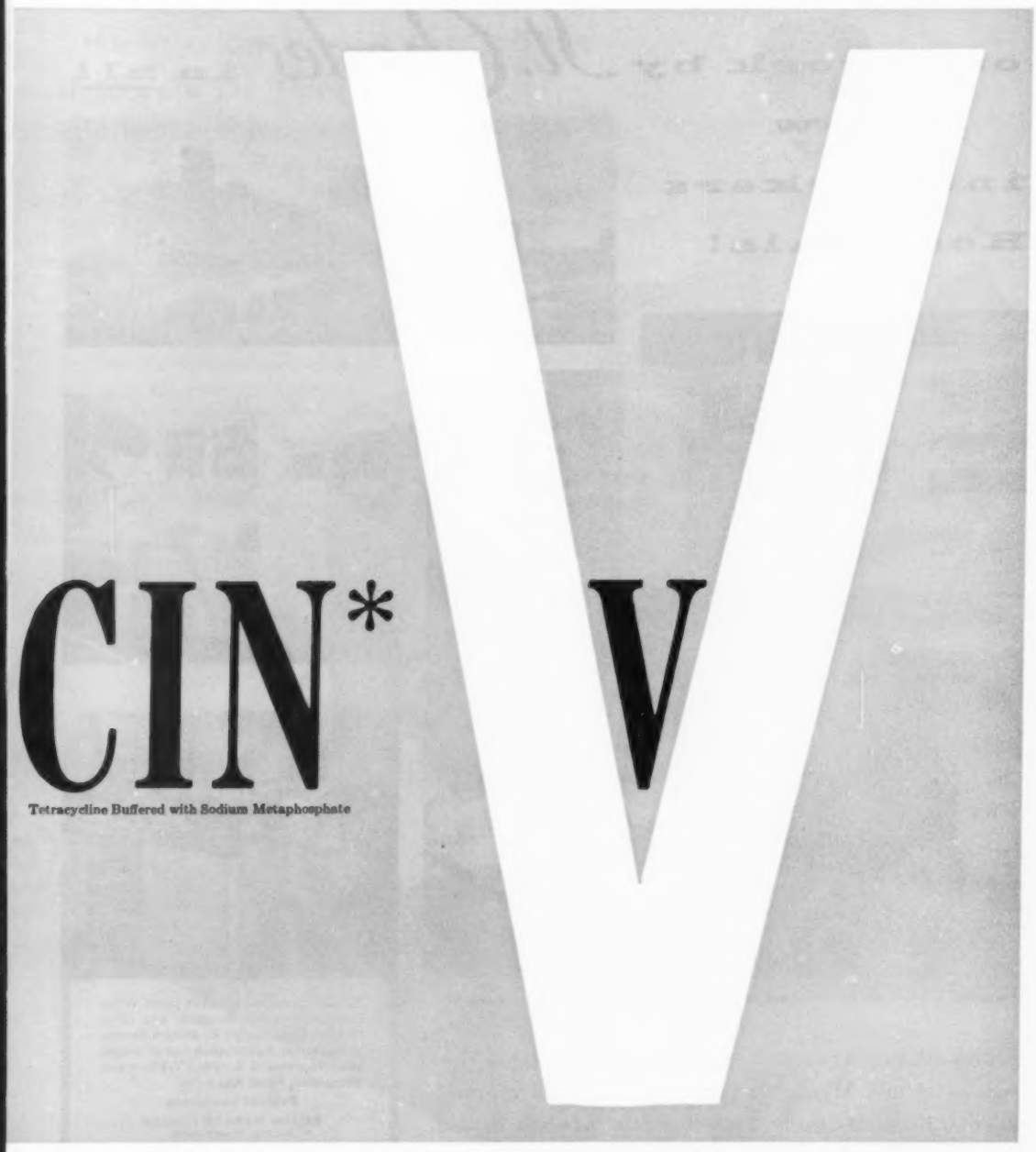
At the frontiers of progress you'll find **An Air Reduction Product** . . . **Ohio:** Medical Gases and hospital equipment • **Airco:** Industrial gases, welding and cutting equipment, and acetylenic chemicals • **Pureco:** Carbon dioxide, liquid, solid ("Dry-Ice") • **National Carbide:** Pipeline acetylene and calcium carbide • **Coltop Chemical:** Polyvinyl acetates, alcohols and other resins. AIRCO



NOW WITH STANDARD TETRACYCLINE DOSAGE

- EXTRA RAPID ANTIBIOTIC ABSORPTION
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- FASTER BROAD-SPECTRUM ACTION

ACHROMYCIN V **Bottles of 16 and 100 Capsules**

Each Capsule (Pink) contains:

Tetracycline equivalent to tetracycline HCl	250 mg.
Sodium metaphosphate.....	380 mg.

It's casework by *St. Charles* in all 10 new Mineworkers Hospitals!

Architects: Isadore Rosenfield, New York; York and Sawyer, New York; Sherlock, Smith and Adams, Montgomery, Alabama

In selecting casework to meet the complex needs of 10 new Mineworkers Memorial Hospitals, the final choice was casework by St. Charles *throughout all 10!* Proof once again that St. Charles' reputation for quality, dependability and economy meets the test of exacting requirements.

St. Charles' long experience and highly skilled personnel, backed by the nation's newest, most modern casework construction facilities, stand ready to help you on any problem of casework and design. Your inquiries receive prompt attention.

A request on your letterhead will bring our 40-page catalog, "St. Charles Hospital Casework."

Shown above are pictures taken at the Beckley Memorial Hospital, one of 10 recently constructed by Miners Memorial Hospital Association under United Mine Workers of America Welfare and Retirement Fund Auspices.

Project Locations

Beckley Memorial Hospital
Beckley, West Virginia

Man Memorial Hospital
Man, West Virginia

Memorial Medical Center
Williamson, West Virginia

Pikeville Memorial Hospital
Pikeville, Kentucky

McDowell Memorial Hospital
McDowell, Kentucky

Hazard Memorial Hospital
Hazard, Kentucky

Whitesburg Memorial Hospital
Whitesburg, Kentucky

Wise Memorial Hospital
Wise, Virginia

Harlan Memorial Hospital
Harlan, Kentucky

Middlesboro Memorial Hospital
Middlesboro, Kentucky

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You can rely on Sperti Faraday to speed the flow of goods and services in all stages of production and in all walks of life. Pioneers in industrial, commercial and institutional signaling systems, Sperti Faraday precision engineered products meet today's need for maximum efficiency in audible and visual communications.

For information on how Sperti Faraday engineering can help increase efficiency while lowering your cost of communications, write to Sperti Faraday, Inc., Adrian, Mich. In Canada, write Sperti Faraday, Ltd., Montreal.

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MATTRESS PADS

in Flat style and new Fitted type

LOOK WHAT YOU GET!

- *Preshrunk in width, outwears ordinary pads*
- *Finest, double-woven bleached cotton felt*
- *No quilting, no filler to lump. Easier bedmaking*
- *Lightweight handling, laundering, storing*
- *Machine washable at any temperature. Fast drying*

BATES BLEACHED FITTED PAD—1304

Single or double sizes . . . 36 to carton

BATES BLEACHED FLAT PAD—1302 (not shown)

sizes 17x18 or 26x34, 12 doz. to carton, 1 doz. to package
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Bates **NEWEST COTTON BLANKET**

in vat-dyed Hospital Green

Now, add a soothing touch of color to your hospital rooms! Soft, gentle green, especially developed by Bates for hospital use. So popular for years in white, this softly napped blanket is tightly woven and finished with firm, whipped edges to withstand heaviest wear and washing. Use as light cover, as warm sheet, or ether blanket.

sizes 68x90, 68x99, 68x108 • 50 or 100 to a case

FOR NAME OF YOUR NEAREST BATES DISTRIBUTOR, WRITE TO: BATES FABRICS, INC., INSTITUTIONS DEPT., 112 WEST 34 STREET, NEW YORK

How *high velocity* solves problem of *flexibility* in the Medical Towers

When the new Medical Towers Building in Houston, Texas was planned, the key air conditioning problem was flexibility. Professional office areas had to be subdivided *after* the building was completed. Here's how an Anemostat dual duct high velocity air distribution system solved the problem.

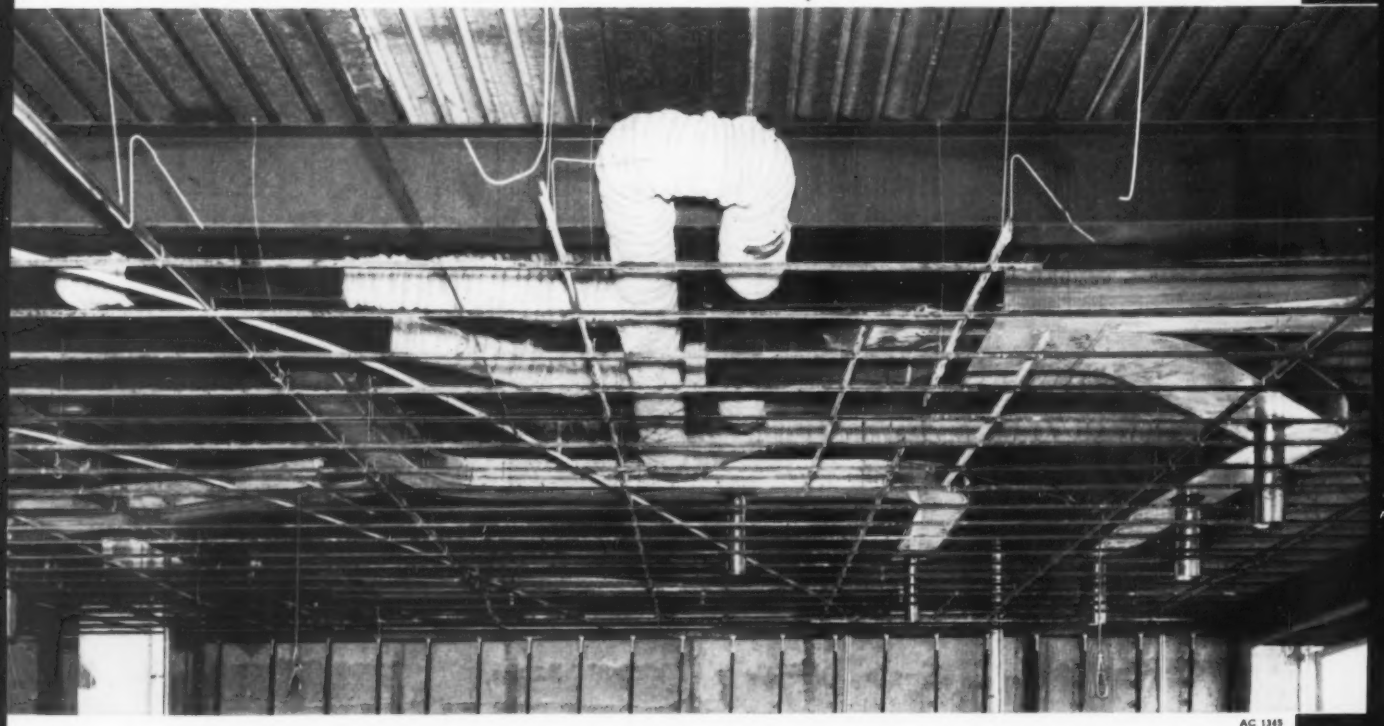
As shown in the diagrammatic sketch, a system of perimeter take-offs from the hot and cold ducts enables each doctor to provide the exact temperature he wants. Temperatures in the various rooms of each suite of offices can be varied. Air distribution is draftless, comfortable, perfectly suited to tenants' needs.

The Anemostat All-Air High Velocity distribution system offers further important advantages. It can be used with smaller than conventional ducts. It can be installed in less time and at less cost. It requires no coils, thus eliminates leakage, clogging and odors.

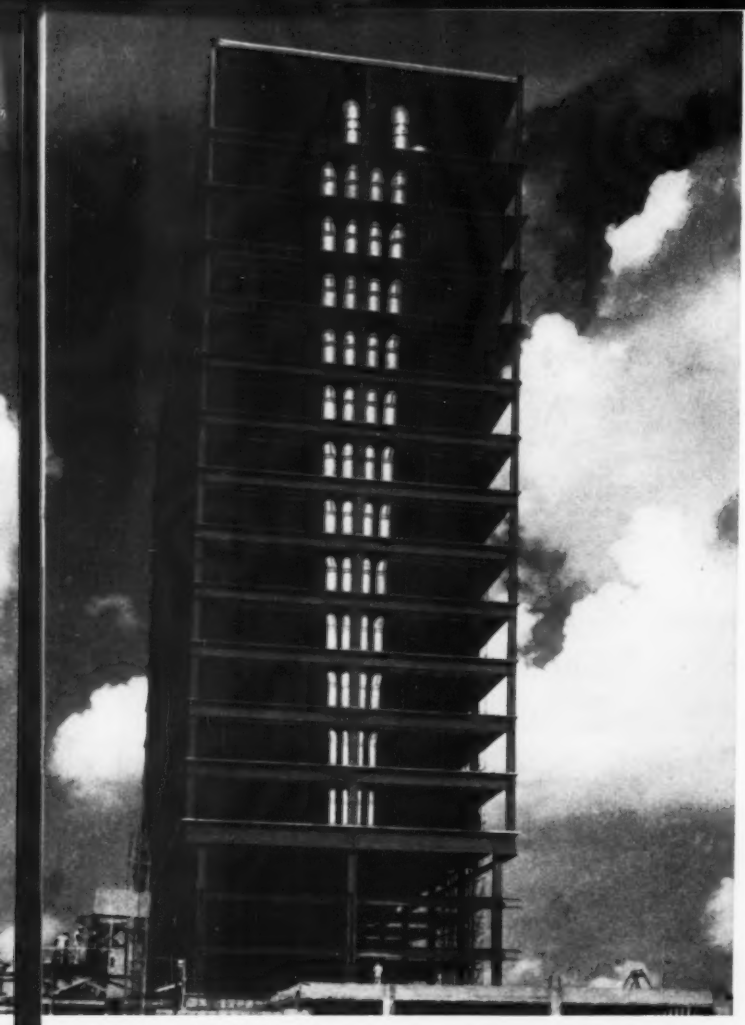
ARCHITECTS—Attention Please:
Anemostat round, square and straightline diffusers with high velocity units are adaptable to a wide variety of architectural designs.

Architects: Golemon and Rolfe, AIA, Houston
Consulting Architects: Skidmore, Owings and Merrill, New York
Consulting Engineers: Bernard Johnson and Associates
General Contractor: Tellepsen Construction Co.
Air Conditioning Contractors: Straus-Frank Company

Anemostat HPE units and duct connections installed in office before construction of ceiling and walls



AC 1345

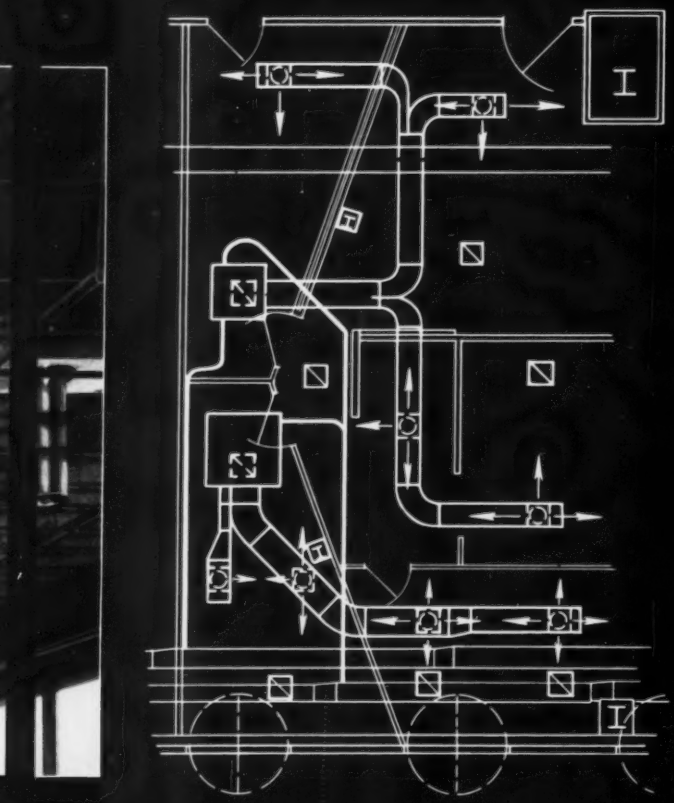


◀ Note how locating of hot and cold ducts saves space in new Medical Towers Building, Houston, Texas

View of lobby showing Anemostat Air Diffusers

View of professional reception room

◀ Layout of typical suite



Write on your business letterhead for your copy of

New Anemostat Selection Manual 60

to Anemostat Corporation of America, 10 East 39 Street, New York 16, N. Y.

ANEMOSTAT: The pioneer of All-Air High Velocity Systems

H. D. Moreland, Manager, Westinghouse X-ray Department discusses

Expansion of facilities to serve you better

"Here at the X-ray Department in Baltimore our whole concern is satisfying your requirements for the finest in X-ray equipment. With the highest production in our history overflowing our past facilities we have expanded our production by 50%.

"Your continually growing acceptance of our products is responsible for this rapid expansion.

"Our enlarged engineering and laboratory facilities will ensure continued leadership in providing you with the finest in X-ray equipment.

"Won't you stop in and visit us?"

YOU CAN BE SURE...IF IT'S

Westinghouse

MEDICAL X-RAY

X-RAY DEPARTMENT

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What's Your Oxygen C.P.P.* ?

* Cost Per Patient—the ultimate cost to the hospital per hour of effective treatment.

STOP AND THINK a moment about the cost differential between the amount you pay for oxygen per cubic foot and what it actually costs you to render an effective treatment. You'll find that the additional expenses of nurses, orderlies, records clerk, and maintenance and storage facilities radically increase the ultimate cost of oxygen to the hospital.

LINDE can help you to reduce the over-all cost of oxygen per patient. We can furnish ideas and visual aids that will help you to cut costs of oxygen installations, operations, and treatments. We can even assist you in setting up an efficient bookkeeping system. We can show you how to avoid accidents. We offer advice in planning and installing an efficient storage and distribution system.

Oxygen information and practical aid for hospitals has always been a LINDE service. To find out how you can get the most from *your* oxygen dollar, just call or write the LINDE office nearest you.

Linde Trade-Mark

LINDE AIR PRODUCTS COMPANY

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NEW VINYL Fabron®

WALL COVERING

. . . Announcing its pace-setting reformulation

At long last: a New FABRON—the answer to the demand for a truly tough, all-purpose, low-cost, decorative wall treatment that will resist ordinary damages. Research and years of experience have now made possible the fusion of a multi-layer armor of "Krene" Vinyl film (reg. trademark of Bakelite Co.) to a sturdy fabric base. The result . . . a unit of strength unprecedented in the low-price wall covering group.

New FABRON introduces eminent standards of performance through the development of all the advantages which brought fame to the "old" FABRON in the last 16 years. In addition, it provides—for the first time—perfect protection to color and print, both permanently locked* between layers of Vinyl . . . inaccessible to damages. Styled in harmony with the latest national surveys of color and design, it combines strength and efficiency with economy to emphasize the obsolescence and the high cost of traditional, commonplace wall treatments. *Clip and mail the coupon below for further information.*

ONLY NEW VINYL FABRON COMBINES ALL THESE ADVANTAGES:

- **Unequalled toughness and durability**
- **Remarkably low initial cost**
- **Unlimited washability**
- **Beautiful sunfast, locked-in colors**
- **Plaster-crack proofness, fire-spread prevention**
- **Easy hanging, pre-trimmed width**

FABRON + PERMON

The winning team for multiple wall problems

For the protection and decoration of wall areas subjected to greater-than-average abuse, there is no stronger surface available than PERMON—the heavy-gauge, fabric-supported Vinyl wall covering. With their coordinated colors, FABRON and PERMON perform together perfectly: PERMON for the wainscot, FABRON for the upper wall—a combination that is as economical as it is attractive.

*a Toscony process

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230 PARK AVENUE, NEW YORK 17, N. Y.
ESTABLISHED 1913

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230 Park Avenue, New York 17, N. Y.

Please send me complete information on New VINYL FABRON.

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ADDRESS_____

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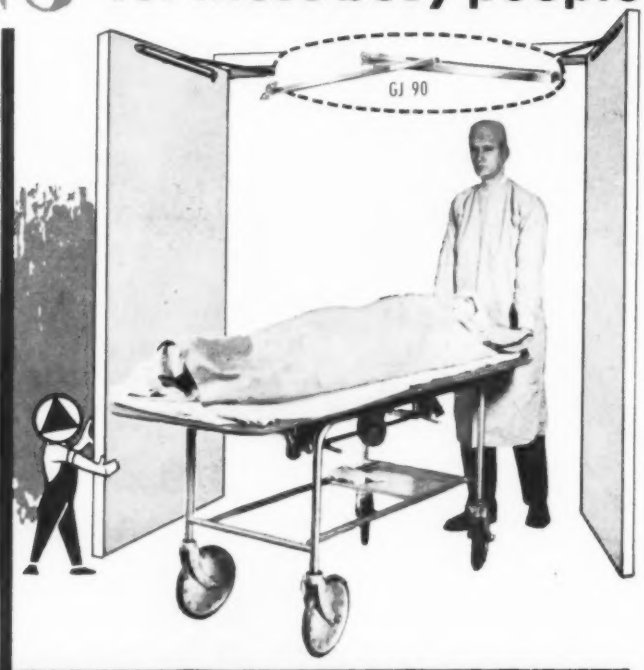
FILL IN THIS COUPON, CLIP TO YOUR LETTERHEAD AND MAIL TODAY!

let GJ HOLD DOORS for these busy people



a variety of silent, shock absorbing door holders for every hospital door

. . . doors leading to patient, emergency, operating, utility, x-ray, supply rooms and diet kitchens—every door through which the busy staff must pass.

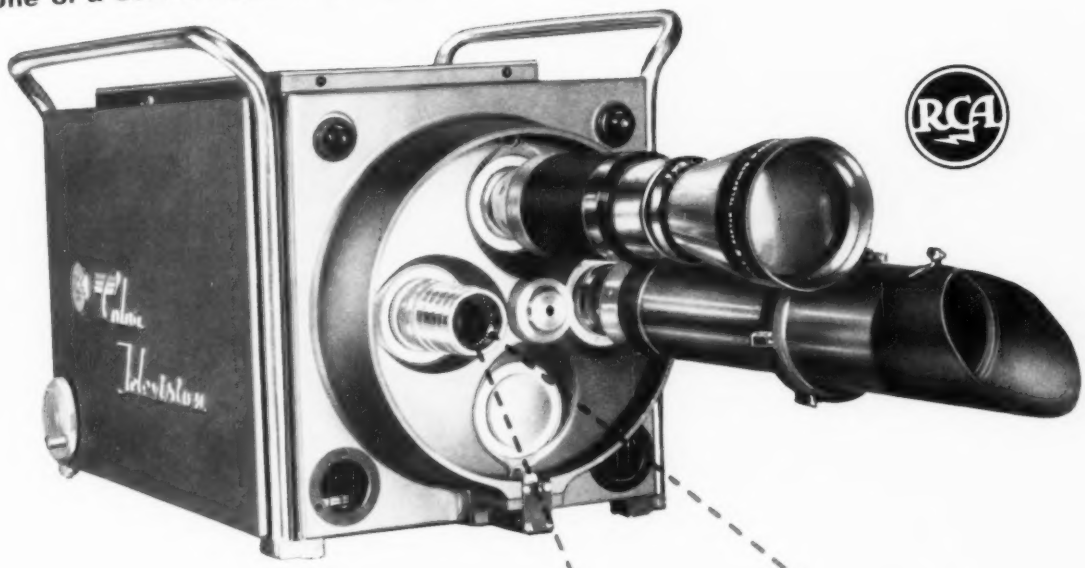
GJ devices go into hold-open silently . . . absorb the shock of a hard opening push. They hold the door securely and yet the door can be released easily with a firm push or pull.

Let us send you this brochure of GJ hardware for hospitals—just write

Be sure it's GJ • the trouble-free hardware maintenance people prefer

GLYNN • JOHNSON CORPORATION
4422 n. ravenswood avenue • chicago 40, ill.

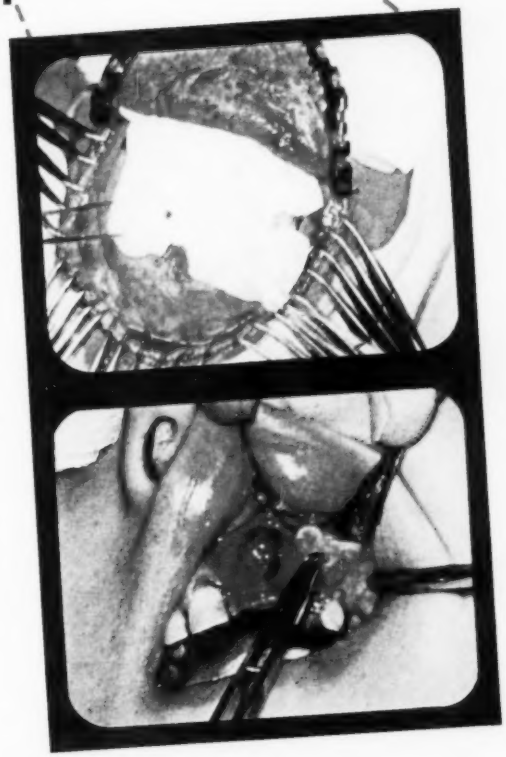
One of a series explaining the successful application of television to education.



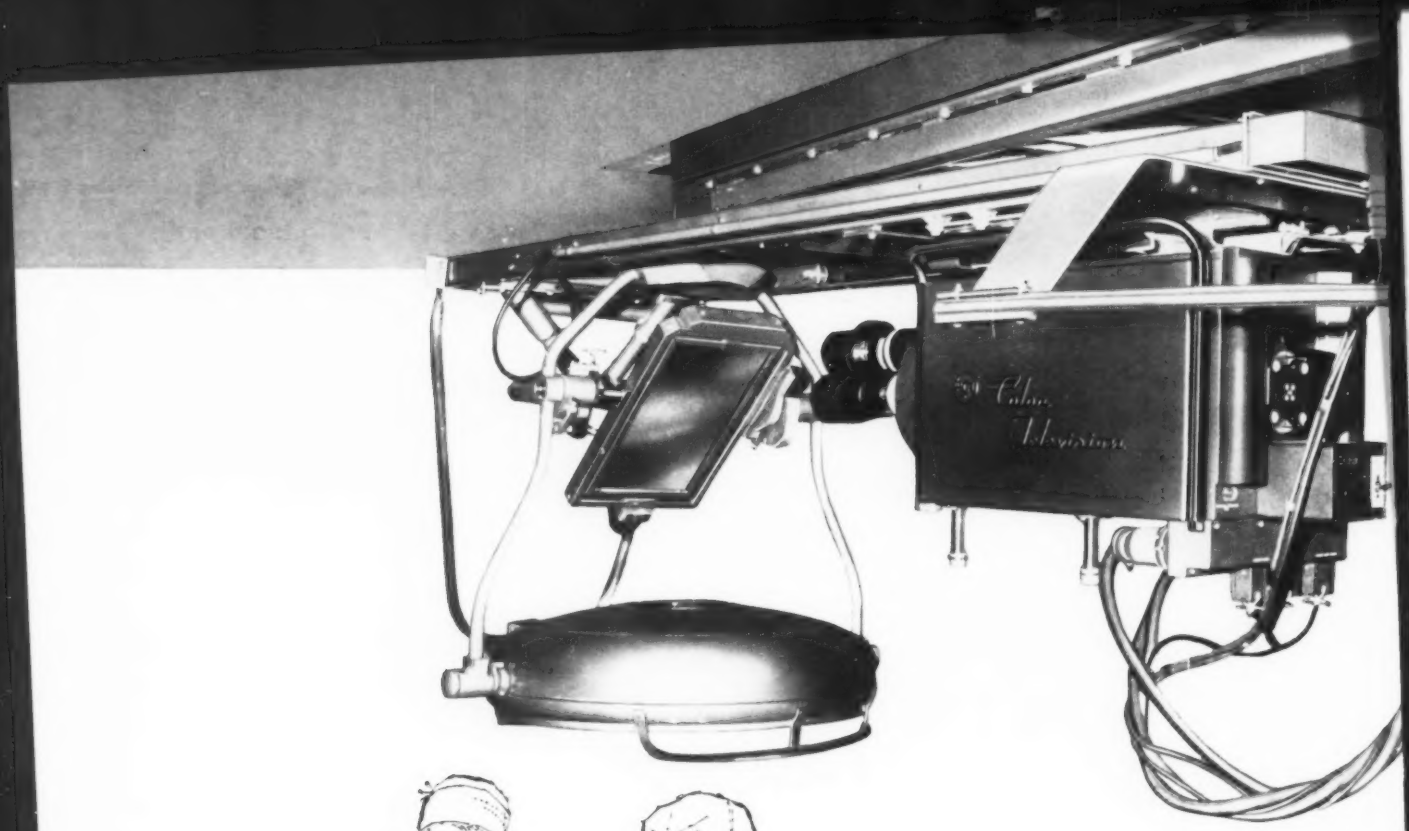
Hundreds of Students See These Close-Up Views of Surgery Via Color Television

RCA medical color TV cameras pick up detail views of surgical procedures and send them to television screens at many locations where they are viewed by hundreds of students. Each student, in effect, stands at the surgeon's side as the operation takes place. He sees a large, close-up view which has the impact and realism of natural color.

Courtesy: Pfizer Laboratories



See additional particulars . . . . next page



EFFECTIVE INSTRUCTION IN SURGERY BEGINS WITH AN *RCA COLOR TV CAMERA*

The RCA medical color TV camera illustrated here is especially designed for televising close-up views of surgical procedures. A special mounting fixture allows the camera to be suspended above the operating table. A specially designed surgical lamp illuminates the operating area, and the camera views this area through an opening in the lamp fixture via a built-in mirror. These close-up pictures are sent over a closed-circuit hookup to any number of television screens where hundreds of students may see them.

Other cameras and related equipments are available for many applications in medical instruction—for demonstrating clinical procedures, for large screen presentation of microscopic specimens, etc.

For literature and further information on the use of television in medical instruction, write Dept. 73, Radio Corporation of America, Bldg. 15-1, Camden, N. J.

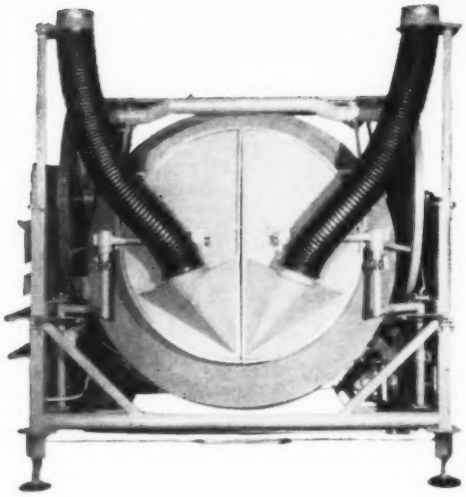
RCA

Tmk(s)®

RADIO CORPORATION OF AMERICA

Broadcast and Television Equipment - - Camden, New Jersey

Have You Troubles?



Such as

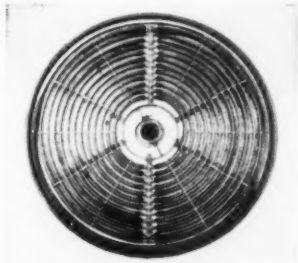
1. Are you tearing off buttons and having torn garments when breaking up cakes?
2. Can't you get rid of extractor wrinkles?
3. Do you have excess moisture causing slow-down of ironing operation?
4. Have you an unloading bottleneck due to loading and unloading from the same side?
5. Are you using old fashioned hand shake-out method with heavy labor costs?

PURKETT'S 72" PCTs* Will Solve ALL of Them

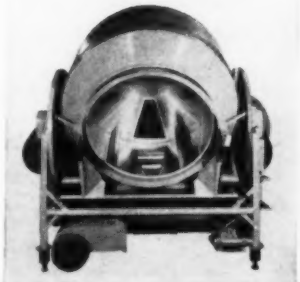
And more, too, because in addition to solving those troubles you'll find a host of other accomplishments, such as: The elimination of hair from barber towels; the elimination of pellets from diapers; 20% moisture content removed in only 5 minutes tumbling time; new 8" vents eliminate the heat and lint output menace from the work room; re-runs eliminated with excessive moisture removed and the remainder properly distributed; increased production with less employee fatigue; although processing time reduced, quality of conditioning of garments and flatwork decidedly improved.

You might get some very profitable ideas by investigating this further. We have informative literature for the asking.

* **Pre-Drying Conditioning Tumbler.**



35% more heating surface with the new 12-ring coil construction.



Unloading position shows powerful 5" Blower; also removable cleaning "door" to get to coils.

Naturally it's a PURKETT

Purkett equipment is sold by ALL Major Laundry Machinery Manufacturers and by

PURKETT MANUFACTURING COMPANY
Joplin, Missouri
DEPENDABLE PRE-DRYING CONDITIONING TUMBLERS

Operating Room floor is Conduct-O-Tile, which is also used in all adjoining areas. It is permanently conductive, needs no special treatment, and contains no free carbon to be tracked into other areas. Floor: ¾" Squares Sprinkle Pattern, Jet Conduct-O-Tile and Green Granite. Operating Room walls: 56 Leaf Green. Color Plate 359.

Instrument Room has Conduct-O-Tile floor in ¾" Squares Sprinkle Pattern, Jet Conduct-O-Tile and Green Granite; easy-cleaning walls in 81 Spruce Green reaching to the ceiling. Color Plate 360.

Doctors' Scrub Room features ¾" Squares Sprinkle Pattern Conduct-O-Tile on the floor. Color Plate 361.

Sterile Supply Storage Room at Johns Hopkins, part of the operating suite, has floors of Conduct-O-Tile, tiled walls in 52 Daffodil. Color Plate 362.

IN THIS NEW OPERATING SUITE . . .

Permanent, trouble-free walls and floors of American-Olean Tile

In the new wing of the Johns Hopkins Hospital in Baltimore, designed by Architect James R. Edmunds, Jr., American-Olean Tile walls and floors were widely used throughout the entire operating suite.

The eye-resting colors are a boon to doctors and nurses. Conduct-O-Tile floors eliminate the main cause of anesthetic explosions by safely dissipating accumulations of static electricity. Tile's durability and low upkeep cost is a significant factor, and it can be kept spotlessly clean and absolutely sanitary with speed and ease.

Whenever you specify American-Olean Tile, you can be sure that its precise color control, great dimensional accuracy, and its self-spacing features will give you the best possible installation.

NEW! FOR HOSPITALS, Schools, and Institutions. 8½" x 4¼" glazed wall tile. Gives you greater design freedom, with substantial savings in cost. Especially suitable for corridors, cafeterias and other large areas.

AMERICAN-OLEAN TILE COMPANY

Executive Offices: 1268 Cannon Avenue, Lansdale, Pennsylvania
Factories: Lansdale, Pennsylvania • Olean, New York
Member, Tile Council of America, Producers' Council

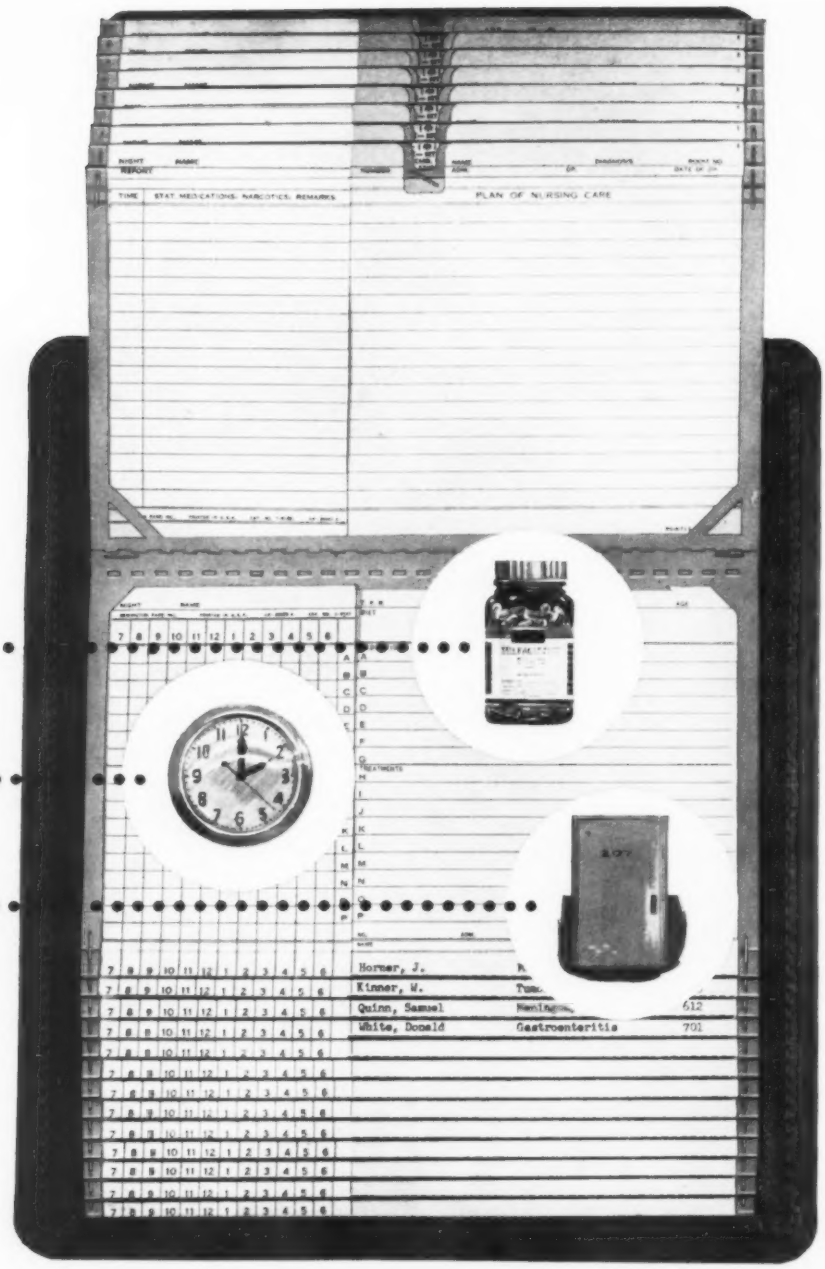
Autoclaves are surrounded by heat-proof, moisture-proof ceramic tile, in 64 Labelia. Floor: 1/16" Squares, Dark Gray and Light Gray. Plate 363.

Write for Booklets 600 and 900 showing color photographs of many actual hospital and school installations, with complete tile descriptions, and for Folder 506 giving complete facts on Conduct-O-Tile.

WHAT.....

WHEN.....

WHERE.....



PATIENT MEDICATION AND TREATMENT CONTROL

in one simple, compact, time-saving KARDEX® *Desk Unit*

What you see easier and faster you control better, and that is exactly what you accomplish with KARDEX Treatment Control. Treatment and medication records are conveniently and compactly maintained in a KARDEX Desk Unit. Colored signals flash treatment time. Patient's name and room number are also in the visible margin. Type of medication or treatment is letter-keyed on the face of the card. All the information you need for fast, accurate, complete control of patient treatment and medication ... available at a glance.

There is more detailed information in a free illustrated brochure. Write to Room 1378, 315 Fourth Avenue, New York 10, New York. Ask for KD789.

Remington Rand

DIVISION OF SPERRY RAND CORPORATION

Reduce Blood clotting

in needles, intravenous and transfusion apparatus, oxygenators, etc.

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4 ounces of this concentrate makes 25 pints of solution: Enough to SILICONIZE 7800 6-inch test tubes! 4 oz. bottle **$3.50**

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● applied in solution of 1:100 parts of ordinary tap water ● imparts to glass (plastic, metal) a smooth, hard surface that drains rapidly and completely ● facilitates cleaning of blood handling and storage equipment ● prevents clotting of needles during blood transfusion ● non-toxic to all body tissues

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CLAY-ADAMS

NEW YORK • 10

Erythromycin in Treating Pneumonia

A 27-year-old man, a chronic alcoholic, was admitted with a history of an alcoholic spree followed by a cough, greenish sputum and chills and fever.

Physical examination showed a temperature of 104 F. and indicated pneumonia in the right lower lobe. This was confirmed by X-ray. The sputum revealed gram-positive diplococci and blood culture subsequently grew Type VII pneumococci.

The patient was treated with erythromycin, 300 mg. every six hours per os. His temperature dropped to normal by 48 hours and X-ray of the chest revealed considerable clearing by the fourth hospital day. After 10 days hospitalization, the patient was fit for discharge.[1]

First Antibiotics Symposium, we reported the successful treatment with hromycin of *H. influenzae* pneumonia and bacteremia. A second patient with *H. influenzae* pneumonia and bacteremia had a clinical course almost identical to the one previously reported, with cure obtained by treatment with 500 mg. of erythromycin per os every four hours for 14 days.

Of these 132 patients with bacterial pneumonia, 127 (96%) had a good clinical result. One patient with lobar pneumonia had a good initial response but had delayed resolution after treatment.

"Highly Effective in Pneumonia"

In one investigation, 75 adult patients with bacterial pneumonia were treated with erythromycin. In his summary, the clinician reported: "It is concluded that erythromycin is highly effective in the treatment of pneumonia due to gram-positive bacteria."[2]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when you prescribe ERYTHROCIN. Abbott

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Erythrocin®

(Erythromycin, Abbott)

STEARATE

"No Serious Side Effects Occurred"

After a study of 171 patients treated with erythromycin, the investigator wrote: "No serious side effects occurred with prolonged therapy or with doses up to 8 Gm. per day in the severe infections."[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. In addition, you'll find allergic manifestations rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), in bottles of 25 and 100. Abbott

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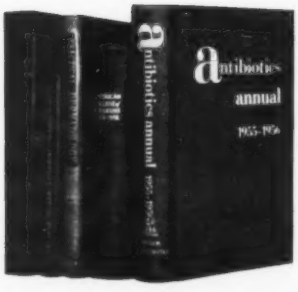

1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48,
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

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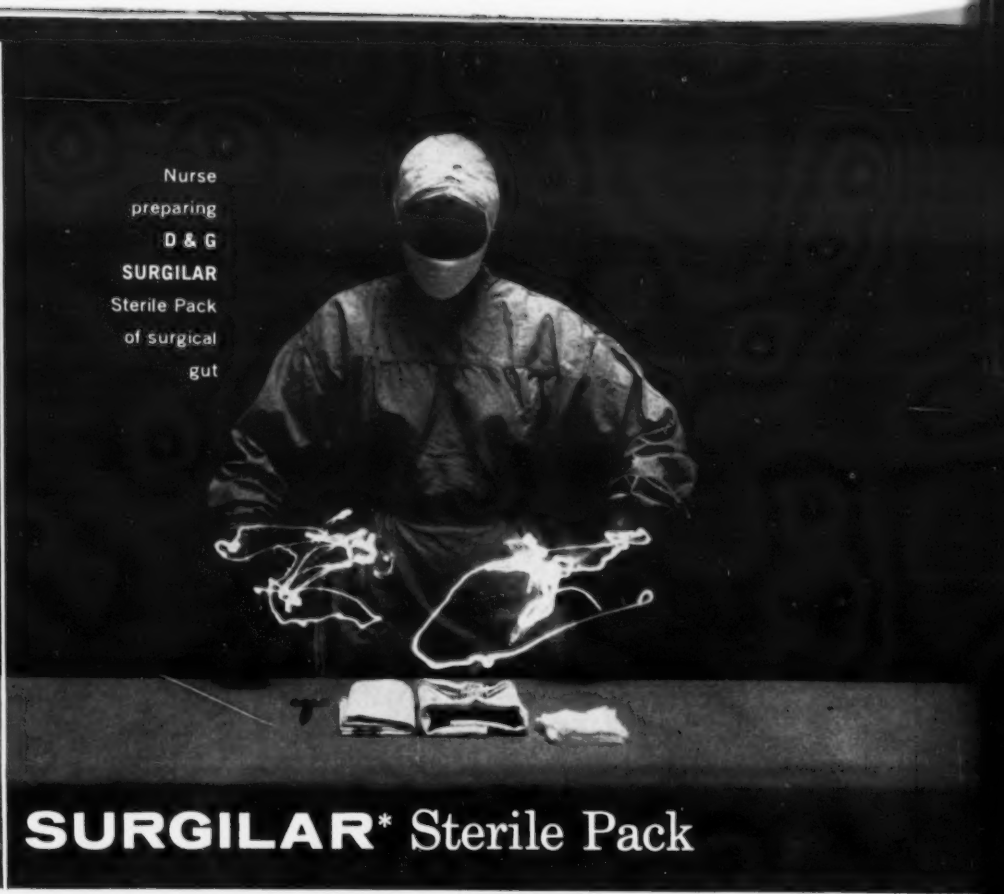

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photo technic: *light-tracings of hands to which bulbs are attached.*

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Little Rock	Central Surgical Company, Inc.
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Fresno	Bischoff's
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Denver	A. S. Aloe Co.
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Washington	American Hospital Supply Corp.
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Jacksonville	Medical Supply Co.
Miami	Florida Physicians Supply
Miami	Medical Supply Co.
Orlando	Medical Supply Co.
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Tampa	Anderson Surgical Supply Co.
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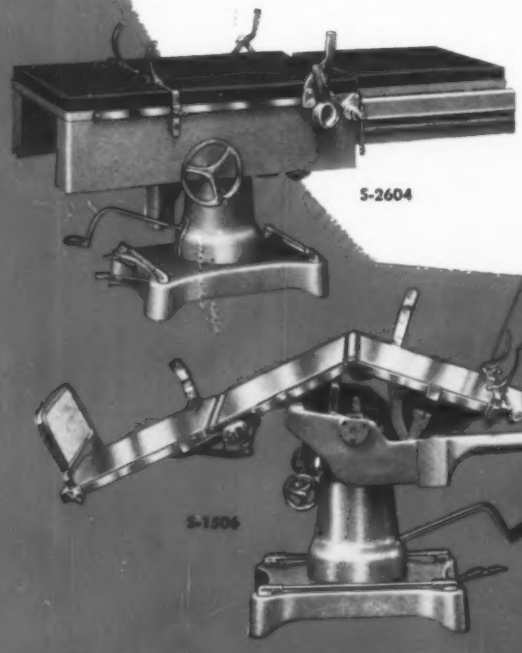

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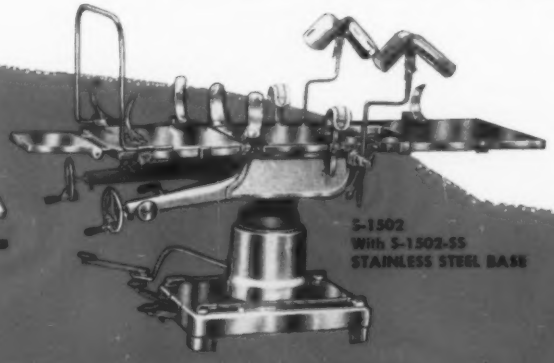

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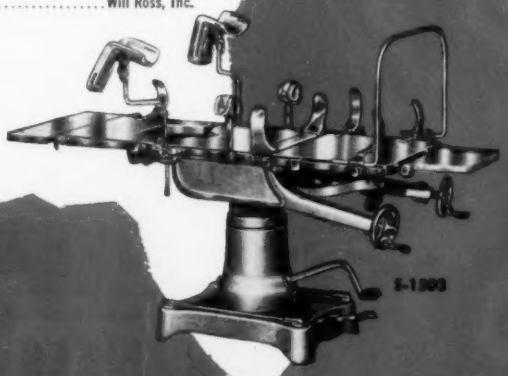

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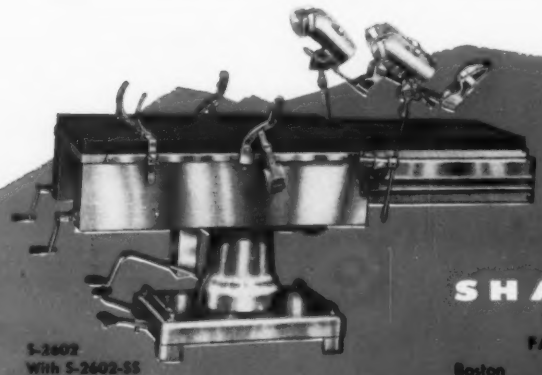

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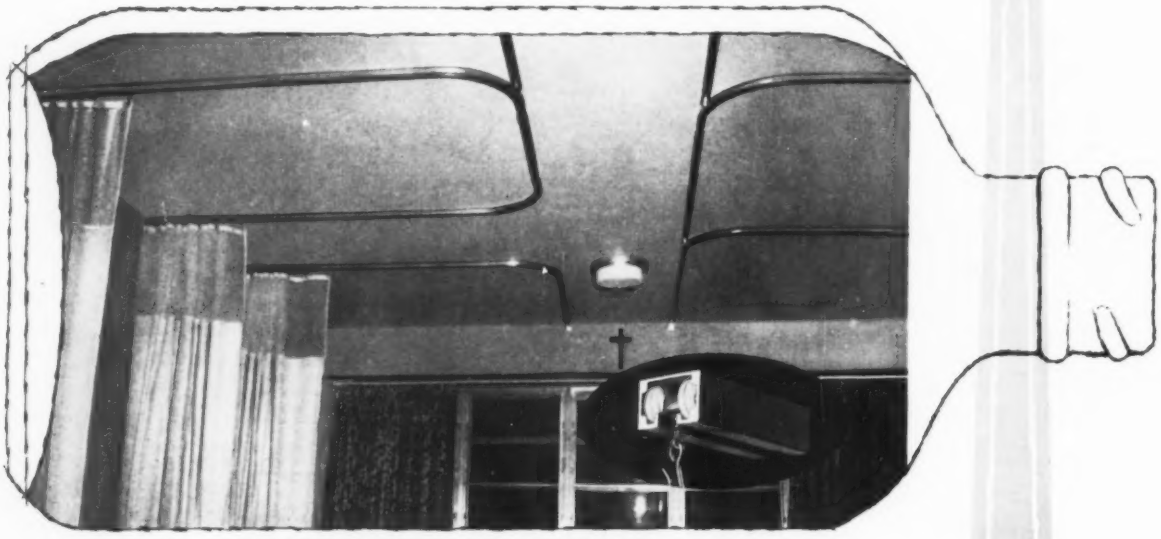

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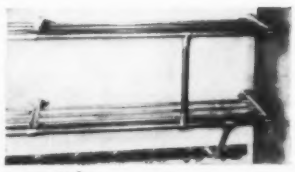

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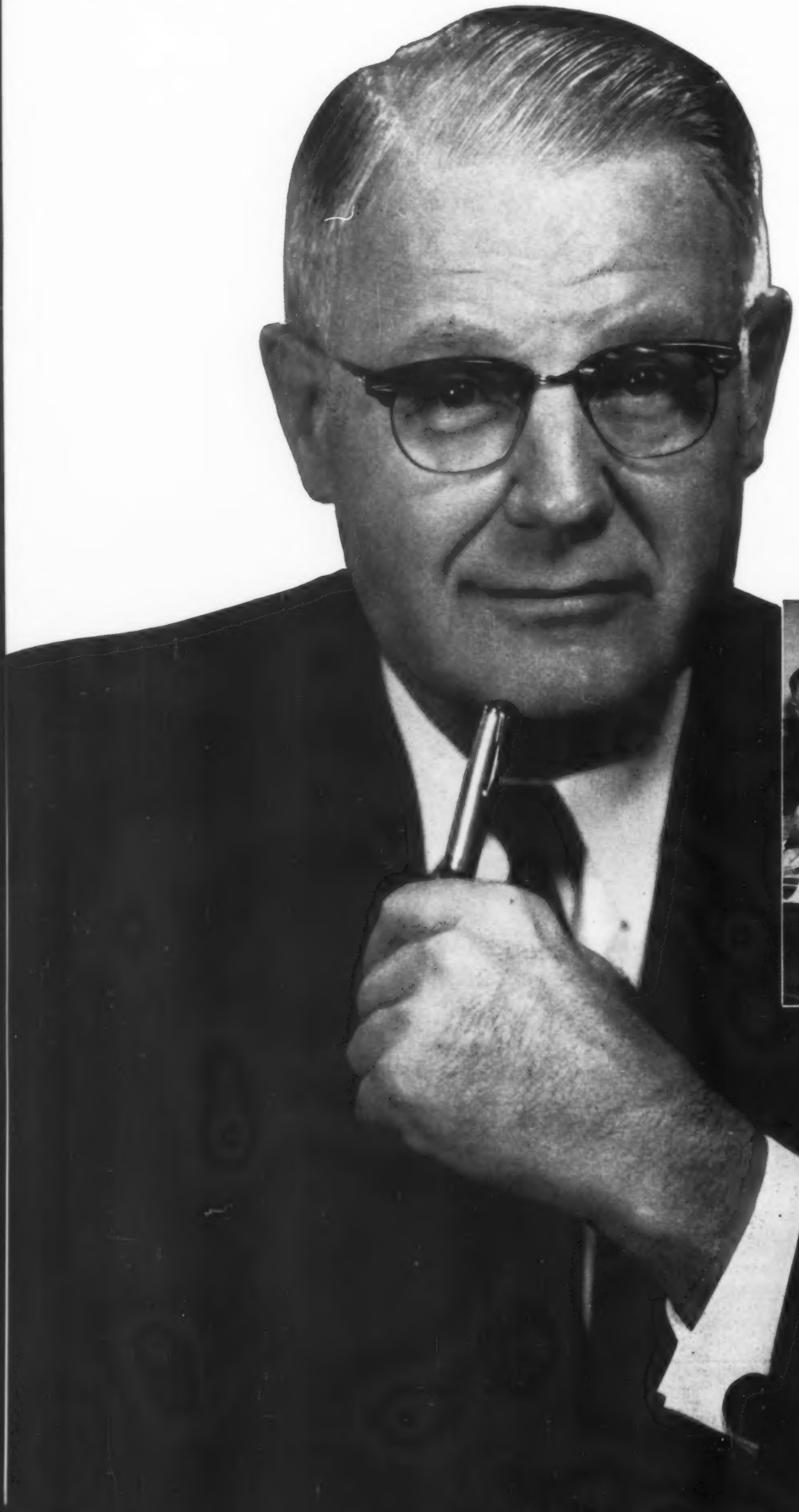

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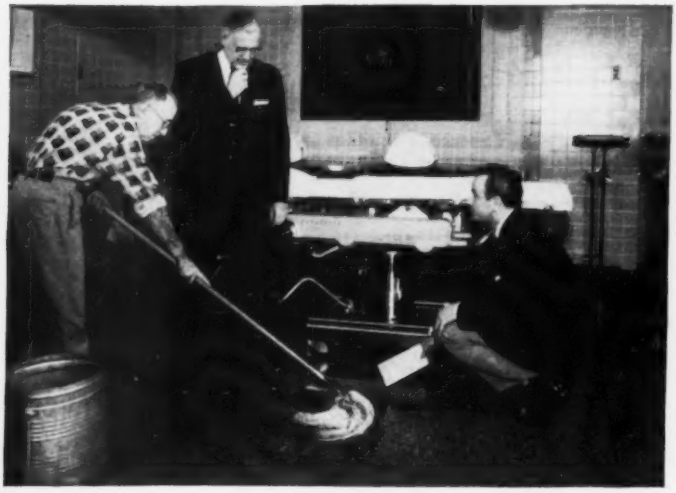

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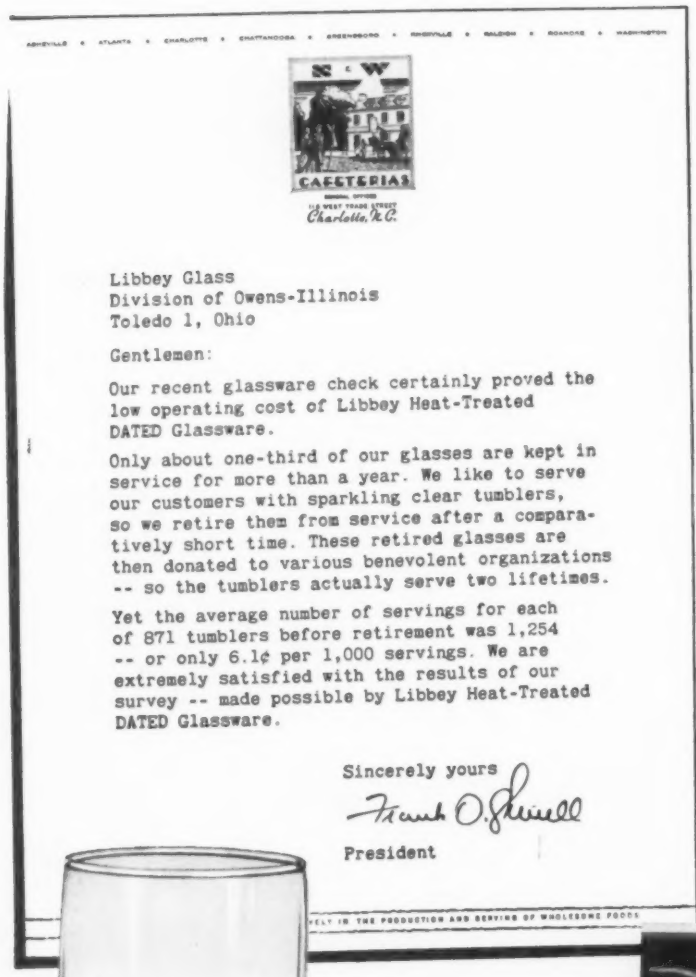

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Only about one-third of our glasses are kept in service for more than a year. We like to serve our customers with sparkling clear tumblers, so we retire them from service after a comparatively short time. These retired glasses are then donated to various benevolent organizations -- so the tumblers actually serve two lifetimes.

Yet the average number of servings for each of 871 tumblers before retirement was 1,254 -- or only 6.1¢ per 1,000 servings. We are extremely satisfied with the results of our survey -- made possible by Libbey Heat-Treated DATED Glassware.

Sincerely yours
Frank O. Sewell
President

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Restaurant operators throughout the country have proved to themselves the economy of Libbey Heat-Treated DATED Glassware.

The unique program of S&W Cafeteria in Atlanta, Georgia, assures patrons of sparkling tumblers at all times. Glasses are kept in service for about one year and are then "retired"—turned over to local benevolent organizations to serve a second lifetime helping the community.

You can easily check your own glasses. The Heat-Treated mark on the bottom of each tumbler indicates date of manufacture—left number shows year and right shows quarter. Add up the number of servings to see the economy of Libbey Heat-Treated DATED Glassware—backed by the guarantee: "A new glass if the rim of a Libbey 'Safedge' ever chips."

HT-1810
9-ounce tumbler

At right, Libbey Heat-Treated DATED Glassware is being easily checked in S&W Cafeteria by the Heat-Treated mark on the bottom of every glass.

LIBBEY HEAT-TREATED GLASSWARE
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① **You save time.** Following simple cutting directions, you get perfect slices of top-quality pasteurized process American cheese—in seconds.

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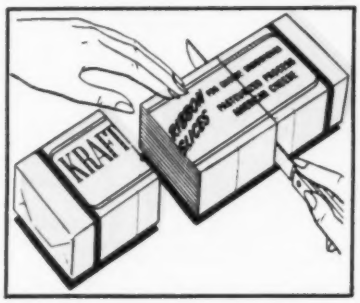
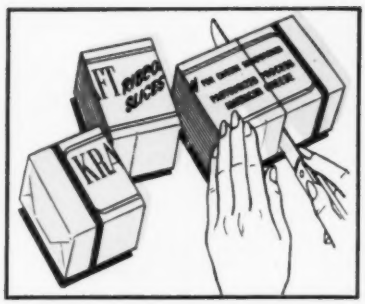
③ **You get perfect portions.** Each Ribbon Slice is uniform in size, shape and weight. Unlike bulk cheese, you can measure costs to the penny.





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SMALL HOSPITAL QUESTIONS

Medical Records Essential

Question: In a paper presented at a county medical society meeting and later published in the county medical society bulletin, a doctor in our community recently charged that the medical records requirements for accreditation are unnecessary and cumbersome, and that "hospitals spend 10 per cent of their budgets on medical records, a wasteful expenditure of the public's money." Is there any basis for this charge?—S.T., Calif.

ANSWER: None whatsoever. The medical records requirements for accreditation have been carefully worked out, and are continually reviewed, by the leading medical authorities who are members of the Joint Commission on Accreditation of Hospitals and by the physicians who are on the field staffs of the member organizations of the Commission. The doctor in your community is also misinformed about costs: The average hospital spends from 1 to 1.25 per cent of its budget on the medical records department.

Operating Room Costs High

Question: A breakdown of our earnings (this is a 25 bed hospital) from patients shows that approximately 8 per cent of our income comes from charges for operating and delivery room service, whereas these departments are responsible for about 12 per cent of all expenses, according to our cost analysis. Yet our charges for these services seem to be in line with what other hospitals in this general area charge. Should we increase these charges anyway, or is it expected that there should be a loss on these departments, to be made up by a surplus in some other department?—E.P.C., Kan.

ANSWER: The practice of robbing Peter to pay Paul among hospital departments is generally held undesirable by hospital accounting authorities, who agree that as far as possible each department should be put on a realistic, self-sustaining basis as far as costs and charges are concerned. In this case, you have not indicated whether the percentage figures given include anesthesia costs and charges. If anesthesia costs are not included, the 12 per cent figure for operating and delivery room seems high, compared to the experience of most hospitals, and procedures in these departments should be studied carefully with a view to eliminating unnecessary expense. If costs cannot be reduced, it would seem prudent and necessary to increase charges sufficiently to make these departments self-supporting.

High Shelves No Drawback

Question: We are doing some remodeling and modernization, and in planning our new storage area the architect suggests that shelving in the storage room should be limited to 7 feet in height, to minimize time and difficulty in handling goods above that height and eliminate the necessity of using ladders. It seems to us this practice involves the needless sacrifice of available storage space above the 7 foot shelf.—N.S., Wis.

ANSWER: That's the way it seems to us, too. There would seem to be no good reason for limiting storage shelving to 7 feet above the floor. There are many comparatively slow moving items which can be kept on higher shelves and easily reached, when necessary, by a short, footstool type of ladder.—E. W. JONES.

Where to Put the Kitchen

Question: We are now a 42 bed institution and expect to build an addition making it 75 to 90 beds. We hope to use the old kitchen as a storeroom and build a new kitchen adjoining it. This will be above the engine room, in a separate unit. Would this location above the engine or boiler room be a disadvantage? Would insulation keep engine room heat from the floor of the kitchen? The board expects to have two or three dining rooms—one for doctors, one for personnel, and one for ambulatory patients. How much floor space for kitchen and dining rooms and dietitian's office should be allocated? —H.W.V.K., Pa.

ANSWER: If the kitchen floor above the boiler room is well insulated against heat transfer, and the boiler room itself below the kitchen is well ventilated to remove heat from the upper part of the boiler room, there should be no problem at all in having your kitchen located above the boiler room.

In its recommendations for hospital food service facilities planned for central tray service, the U. S. Public Health Service specifies 1065 square feet for the main kitchen and bakery areas for a 50 bed hospital, and 1605 square feet for a 100 bed hospital. Other area specifications include: dishwashing area, 175 square feet for the 50 bed hospital, and 175 square feet for the 100 bed hospital; dietitian's office, 50 square feet for the 50 bed hospital, and 125 square feet for the 100 bed hospital; dining space, including serving space, for employes, staff and nurses, 520 square feet for the 50 bed hospital, and 1065 for the 100 bed hospital.—E. W. JONES.

Don't Tax Doctors

Question: One of our board members returned recently from a trip to the West Coast and reported that many hospitals there charge doctors a regular tax or service fee for use of facilities for their patients. He has suggested that we should consider establishing such a charge here in order to add to hospital revenues and make possible some capital expansion we have been unable to finance ourselves. Is this good practice?—R.T.M., Iowa.

ANSWER: No, and it is doubtful that your trustee could substantiate his report about "many West Coast hospitals" with factual information. It may be that such a tax or service fee is charged to doctors by some hospitals owned by private individuals or corporations and operated for profit, but there is no evidence that any voluntary, nonprofit community hospitals are making such charges. The occasional reports that are heard—not only from the West Coast but in other areas as well—about doctors being taxed for the use of hospital facilities probably result from the fact that doctors are commonly asked to contribute to hospital fund raising campaigns. In well ordered campaigns, the doctors' contributions are solicited by, or under the careful supervision of, a committee of the medical staff itself, and nothing approaching "high pressure" tactics is ever used.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif., Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

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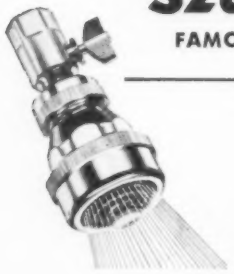

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FEDERAL EMPLOYES HASSLE

Again, the interests most anxious for a health insurance plan for federal employes are at loggerheads over how to set one up. Unless the differences can be compromised, and without much delay, this legislation will fail again this year, as it has for the last two.

The problem is a basic one.

From the standpoint of American Hospital Association and Blue Cross, any program that does not include basic hospitalization coverage would be unacceptable as it would be a threat to the very existence of nonprofit plans. Of this they are convinced.

From the standpoint of the Administration, major medical insurance has to be included in any package; if basic coverage is added, the cost is more than the budget can stand. Also, the Administration so far is not willing to approve payroll deductions, without which, it is agreed, basic coverage would be difficult to maintain.

From the standpoint of the unions, major medical coverage would be fine, but not enough unless accompanied by protection against normal hospital bills.

There has been no lack of argument, discussion and exploration. Seemingly every possibility has been studied. There would be a complete stalemate, except that sponsors of the conflicting plans are determined to work out something that all can accept, even if without enthusiasm.

American Hospital Association and Blue Cross continue to insist that any plan carry the following:

1. **Basic hospitalization insurance** with U.S. meeting about half the cost and the employes the rest through payroll deductions.

2. **Additional benefits** substantial enough to meet full, normal in-hospital costs and surgery bills.

3. **Participation by commercial and nonprofit** (service) plans in both of above types of coverage.

4. **Optional major medical coverage,** so patterned as to supplement but not replace the type of basic coverage now in general operation. Also, retired employes would have to be protected.

To these demands the Civil Service Commission, trying to represent the government, says: "That's all fine, we would like to do it. But it would cost too much."

The Administration's position continues to be that major medical insurance has to be a part of any law. If basic coverage also can be worked into the deal, and the total cost kept down, the government has no objection.

Over the years the position of labor has not varied much. Because most industries help pay the cost of basic health insurance for their workers, labor thinks this type of coverage must be the starting point for any program for federal employes. After that, or with it, could come major medical coverage, but labor won't accept the latter alone.

Currently A.H.A. and Blue Cross representatives continue their talks with the Civil Service Commission, refusing to give up hope for a compromise.

HOSPITAL BILLS PILE UP

Although not many of them will become law this session, bills affecting hospitals continue to pile up. The major ones are worth recording briefly, because if not passed or defeated this year they remain alive and ready for a possibly more energetic session next year, an election year.

A Hoover Commission recommendation for a permanent federal advisory council of health again is before Congress. The commission couldn't do much itself, but, if it wanted to, it could have its agents or investigators looking in on virtually every federal medical operation. The council's job would be to study, review, advise and recommend. An additional responsibility would be to keep under continuous review the total national health picture, private as well as governmental.

Two bills would modify the Hill-Burton law to this extent: eliminate grants to nonfederal associations or groups, even if they were nonprofit, as a means to separate church and state; and allow small states to use money allocated under the amendments part of the act for constructing hospitals that qualify under the original H-B law.

Retired military personnel are not eligible under the present dependent medical care act, although the House committee last year favored their inclusion; a new bill would make them eligible.

Rep. Ed Edmundson (D.-Okla.) thinks the state health state officer such action would create or intensify a hospital close or reduce an Indian hospital, if in the opinion of the state officer such action would create or intensify a hospital shortage in the area.

Several bills propose setting up military medical scholarships, with the graduates pledged to serve in the armed forces (or work for Defense Department as civilians) for periods of time based on the extent of their scholarship help. At various times in the past Defense Department has pushed similar legislation.

DEPENDENT CARE CHANGE

Defense Department has made a change significant to hospitals in the dependent medical care operations.

Up to now, the physician has had to act as sort of collecting agent in cases where a hospital was involved in an out-

patient case and the joint fee exceeded the $15 the patient pays. For example, if in an injury case the hospital or lab costs were $30 and the doctor's fee $50, the doctor would collect $15 from the patient, then submit the balance of his bill ($35) along with the total hospital bill ($30) for collection of payment from the government.

Under the new system the doctor will get the patient's $15, and if his fee is in excess of this amount, submit his statement for payment by the government. The hospital will submit its bill independent of the doctor's.

V.A. RESEARCH PROGRAM

Veterans Administration is strengthening its research program by selecting specific investigators and having them spend three-fourths of their time on research. The rest of their time will be spent in patient care or teaching.

Until the change was made, V.A. research was constantly handicapped by the fact that researchers were expected to spend most of their time on patient care, fitting in work on their projects as best they could.

Also, V.A. will have "an outstanding representative of the special field of medicine" as an adviser to each researcher.

Outsiders as well as V.A. staff men will be considered for appointment as clinical investigators; terms will range from one to three years, with some starting in January and the remainder in June.

DEPARTMENT OF CIVIL DEFENSE

American Hospital Association witnesses have testified before the Holifield subcommittee on hospital aspects of a proposal to set up an independent, cabinet-rank Department of Civil Defense. This bill has the support of the parent Government Operations Committee. The Holifield subcommittee last year held extensive hearings on the general subject of civil defense. Several other bills, supported by neither the committee nor the Defense Department, would create a Department of Civil Defense, co-equal with army, navy and air force, within the Defense Department.

The bill before the subcommittee provides for the establishment of three committees or councils as part of the proposed new department. One would maintain liaison with the military services, another would keep scientific developments in civil defense under constant survey, and the third would maintain contact with state, local and private organizations interested in civil defense.

Among responsibilities of the CD department would be development of a national "master" civil defense plan that would provide for:

1. **Warning instructions,** emergency travel arrangements, emergency shelter and a communications network to be put into operation in case of need.

2. **Arrangements for the stockpiling** of food, clothing, medical and sanitary supplies, including emergency hospitals.

3. **Provision of** emergency welfare services.

Also, the department would be expected to set up schools and training centers for civil defense workers, and a research program in civil defense problems. Because one of the basic objectives is to keep as much control as possible in civilian hands in time of disaster, the department would have certain emergency powers to be invoked if necessary.

The Joint Commission on Mental Illness and Health, at the halfway point in its three-year survey of the nation's mental health problems, thinks it should have more money from Congress.

In its first annual report, the commission lists the projects that are already under way and adds that a dozen more will be undertaken "if additional support is obtained. . . ." The additional money also could come from an outside organization, as permitted in the law setting up the commission.

When created in the summer of 1955, the commission was authorized to spend $1,200,000, and there is not much question that this money at least will be voted by Congress. So far about $200,000 has been spent, but the commission, looking ahead, estimates that it can't do an effective job unless it gets more than the $1 million remaining in the authorization.

FOOD IRRADIATION REACTOR

Eleven industrial firms have asked Atomic Energy Commission for permission to participate in design, development and construction of a food irradiation reactor, a project that holds promise of reducing food handling costs for hospitals as well as the military services.

The reactor, water-moderated and fueled with solid fuel elements, will provide an intense source of gamma radiation for food irradiation and preservation. For many types of food, irradiation would eliminate costly refrigeration.

Site for the reactor will be selected soon by the army.

ALASKA LOSES OUT

Although every effort has been made to provide a Hill-Burton grant for the new mental hospital construction program authorized for Alaska, it now appears that the territory will have to get along on the congressional appropriation or raise money itself. The H-B law requires that grants must be matched by local money; the fact that the only money Alaska now has on hand is the federal appropriation rules out the grant.

NOTES:

Again the Administration is pushing for a law to permit small companies to pool assets so they can experiment with unusual health insurance risks.

If some of the Democrats in Congress get behind "hospitalization at age 65" under social security, they will bump up against formidable opposition from the Administration, which considers this plan dangerously close to compulsory health insurance.

The general anti-inflation clamp-down on any new government construction will not interfere with the Hill-Burton program; if H-B funds are cut, the action will be taken solely in an attempt to hold down the total budget.

Prospects are that in excess of $5 million in medical research funds will be turned back to the Treasury; H.E.W. says it is impossible to spend all the money voted for research last year and still maintain established standards for the projects.

The Modern Hospital
MARCH 1957

LOOKING AROUND

Swarm

WHATEVER one may think of the plan to thump the tub for contributions to help build the American Hospital Association's Dream House at full height, according to the original blueprint, association officers and trustees were right when they called a special meeting of the House of Delegates for March 16 to consider the plan and report back to the states before final action in May. There may easily be an argument, and possibly a bitter one, before the issue is settled, and there are sure to be some who will equate controversy with catastrophe and regret the argument *qua* argument. But the method is right, however painful, and any who are displeased with the result, whatever it is, may find comfort in the wisdom of that well known authority on hospital association procedure, Marcus Aurelius. "What is not good for the swarm," he said, "is not good for the bee."

Wicket People

NOT long ago, we accompanied a little girl we know, or think we know, on a visit to a state office building to apply for her driver's license—an expedition involving an encounter with a member of the species we have come to identify as Wicket People, those natural antagonists of the human race who are often found behind windows and across counters in city halls, post offices, railroad stations, banks and elsewhere. On this occasion the Wicket Person indicated, after prolonged questioning by the little girl, that a certain form was to be filled out. This was done, and the form duly presented, whereupon the Wicket Person pounced on a technical error and rejected it.

The form was completed again, and the same thing happened. When the process was repeated for the third time, we became exasperated and violated our long-standing rule for little girls by intervening.

"Why don't you tell her how to do it?" we asked the Wicket Person. He gave us an evil leer.

"She didn't ask me!" he said triumphantly.

Here, obviously, was an accomplished practitioner of the art. Wicket People make a sporting event out of giving the least possible information without actually refusing to answer questions. Wicket People are always surly but never positively insolent; always obdurate but never absolutely adamant; always grudging but never really obstructive; always provocative but never openly combative. They keep a score of their victories; the Wicket Person who has reduced a majority of his opponents to helpless rage and sent a few, at least, screaming off the premises without accomplishing their purposes can go home happily at the end of the day. In the evening's reverie, he can recall exciting images of faces swollen with wrath and hear again the sweet sound of hoarse, angry voices.

Of course, not all people behind wickets are Wicket People. Distinguishable by a manner that may be haughty, or bored, or baleful, or contemptuous, or any combination of these, Wicket People are the twisted personalities who vent their own frustrations and hostilities on the public; a Wicket Person's meat is another person's choler. On the whole, this is not an uneconomic arrangement. There are not nearly enough psychiatrists to go round as it is; if all the Wicket People were to seek the treatment they need, the overload on psychiatric services would be staggering. As things stand, the burden is not insupportable. Those of us who are a little unstable ourselves and cannot withstand the attrition of daily contact with Wicket People can always pay our license fees by mail, and buy stamps from machines, and stay off trains and out of banks.

The patient or visitor who faces a Wicket Person across a hospital counter or behind a hospital window, however, is really up against it. He is there from necessity, not choice; he cannot remain at home, or deal with the hospital by mail and reject its services altogether. Then, too, he is already tense and frightened because of the nature of his visit. In a hospital, the Wicket Person has an unfair advantage to begin with; a man or woman who is adept at the art can bring on collapse in the briefest exchange, sometimes without even sneering.

Smart Wicket People know, however, that there is a hazard in hospital employment that doesn't exist elsewhere, and they are careful not to go too far. Unlike post offices and railroads, *most hospitals want to serve the public.* Hospital administrators usually do not share the Wicket Person's feeling of self-righteous triumph when the occasional patient or visitor who complains is brought to heel and informed that the Wicket Person has only been doing his job, so it is the complainant who has been unreason-

able. A few administrators are shrewd enough, and care enough about the feelings of patients and their families, to spot a Wicket Person after two or three complaints, *and even to fire him just because he is a Wicket Person!* Moreover, things are getting tougher all the time; the view has gotten abroad lately that there is no place in hospitals for Wicket People, and one hospital authority has gone so far as to suggest that when a Wicket Person is found behind a hospital counter he should be given psychiatric help to see if his behavior can be changed.

For Wicket People, these hazards of hospital life are a challenge, and some of the best practitioners are found at hospital windows. For the less skillful, there are always some hospital jobs. For one thing, there are hospital administrators who don't care what happens to patients and visitors, as long as they can't sue for damages. Then there are some administrators, and even a few nurses and doctors, who are secret Wicket People themselves. If all else fails, any Wicket Person who is worth his gall can always get a job in the driver's license bureau, or go back to railroading.

Costs and Charges

OPINION polls conducted by research organizations, hospital associations and individual hospitals in recent years uniformly have shown patients and their families are more concerned with many other aspects of hospitalization than they are with costs and charges, a circumstance which would indicate that hospital people may make a mistake when they go to the public, as they often do, with explanations about costs and charges—answers to questions that nobody has asked. Considering public response to hospital charges and costs, it is necessary to distinguish between the patient or family that is responsible for paying the entire bill for hospital service itself, those who are covered by one or another form of hospitalization insurance, and those who are the responsibility of still other agencies.

Naturally, the family that is paying its own hospital bill in full is interested in keeping it as low as possible—consistent with the standard of service the family wants and expects. The man who is paying his own bill, however, is not greatly interested or concerned about the relationship of charges to costs. He assumes there is some such relationship in each case, but it is doubtful that he cares much one way or the other.

Thus, if hospitals were dealing only with patients who paid their own bills, there would be considerable logic to a system of charges in which the billing for each service was not related to the cost of that service. The reason for this is plain. Most people have some experience in paying for the room and board aspects of hospital service—in their own homes, in hotels and motels, and through general familiarity with the cost of meals and room accommodations. This awareness doesn't exist at all in the case of such unfamiliar items as the operating room and anesthetic charges, the x-ray and laboratory charges, medications, and other more or less recondite aspects of hospital service. The average patient has no idea how much such services cost, so he may accept without question a service charge that is loaded far beyond cost to make up for deficits incurred in room and board billings that are below cost, whereas he would probably think room charges were too high if they were billed at or above cost.

If the individual private patient were the only concern, the practice of loading service charges to cover room accommodation deficits could be continued indefinitely, and there would be no particular pressure to relate bills to costs by departments. Unfortunately, however, the individual private patient is not the only concern, or even the most important concern. A majority of hospital bills today are paid through Blue Cross or some insurance scheme, by a government or welfare agency, or under one or another of the many company, union, fraternal and other hospital payment programs that are now in operation, and these agencies are greatly concerned about the relationship of costs and charges.

Pricing practices in the hospital are necessarily different from the pricing practices that prevail in business generally. Business pricing must comprehend costs and sales. Some prices near or at cost or even below cost may always be logical under some circumstances in business, as, for example, when a department store may have loss leaders to bring people into the store, where they may be expected to buy some items with long profit margins, or when a manufacturer may accept a contract at a below-cost price in order to hold his working force together for other lines on which he can make substantial profits.

There is no such consideration in connection with hospital pricing. Hospitals do not, or should not, push any particular service or product. They are not trying to sell more of one drug than another, or of one operation than another, or of one laboratory service than another. They are not pricing anything to sell, so there seems no particular reason why hospital prices should not reflect costs closely, in order to meet a most important public relations responsibility—that is, to satisfy the demands of the Blue Cross plans, insurance companies, government, welfare and other agencies which represent the public today in its financial relationship to the hospital.

If a reallocation of charges and costs in all departments should result in loss of revenue to the hospital from some departments, obviously the revenues would have to be made up by adding to the charges for other services. What would happen, from the standpoint of public reaction or public policy, if it were necessary to make substantial increases in the charges for room and board?

The answer is in making these charges not just higher, but more intelligible. A separate charge for nursing service, for example, would be perfectly reasonable and, in the public relations view, perhaps desirable. Some hospitals have already tried this out, without disaster. A separate charge for meals might also prove reasonable. If the time does come when charges for such services as meals and nursing are separated from the hospital room charge, hospitals may be encouraged to institute some other changes that seem desirable—breaking away from the prevailing practice under which it is assumed that all hospital patients require exactly the same amount, and the same kind, of nursing and dietary attention.

Hospital Facilities Should Fit the Patient

Critical care units for seriously ill patients and self-help units for those who are not very ill are recommended for helping the hospital make best use of space, equipment and staff

VANE HOGE, M.D.

THE hospitalization problem ahead might be visualized as falling into two broad segments. The first would include those conditions characterized by rapid onset, intensive treatment, and quick recovery. From the standpoint of age, this segment will consist largely of young and middle-aged persons. The second segment consists of conditions characterized by slower onset, longer duration, and requiring less intensive treatment. In this segment the aged group will be predominant.

TAILORING IS NOT NEW

The tailoring of facilities to the special needs of special categories of patients is not a new concept. Early in the present century there was a trend toward a wide variety of specialized hospitals, such as those for heart, cancer, incurables, children, diseases of women, contagious diseases, and so forth. During the unprecedented wave of hospital construction in the 10 years following World War I, this trend was particularly evident.

During the depression of the 1930's, the rising tide of hospital construction came to an abrupt halt. Moreover, some 600 hospitals closed their doors entirely. This period marked the end of the swing toward specialized hospitals, except those for tuberculosis and mental diseases. The trend was now toward the more comprehensive type of general hospital.

The trend away from specialized facilities resulted not only from economic necessity, but from a growing realization that the patient is rarely the victim of a single disease entity.

MOST H-B HOSPITALS ARE GENERAL

The trend away from the specialized hospital is still going on. During the first 10 years of the Hill-Burton program, 130,000 hospital beds have been built or are being built. Eighty per cent of these are in the general hospital category. The inclusion in the general hospital of even the most traditionally specialized patients, *i.e.* those with tuberculosis or mental disease, is an increasing practice.

Perhaps the trend toward homogeneity as distinguished from comprehensiveness in the general hospital has gone too far. As medical science has increased its scope by leaps and bounds, the science of hospital design and construction has been pushed to keep pace. As a result, hospitals are growing ever more complex and expensive to build, maintain and operate.

I think it is fair to say that in the last 10 years the art and science of hospital design has made greater progress than in all the previous history of hospitals. Strangely enough, however, we seem to have given little thought in our design to the relative needs of different degrees of illness. In other words, our modern hospitals are, for the most part, built around the needs of the acutely ill patient. True enough, the average length of stay in general hospitals has declined steadily in recent years until it is now only 7.2 days per admission. Nevertheless, numerous studies of the patient load in general hospitals have shown that upward of 20 per cent, and in some cases more, of the patients could have been handled just as well in less expensive facilities.

What is the answer to this problem? Will the pendulum now swing the other way toward another system of specialized facilities — one for the acutely ill, one for the convalescent, one for the chronically ill, and one for the aged and infirm? To a considerable degree this trend has already started.

ACT WAS AMENDED

In 1954, Congress, reviewing the progress of the Hill-Burton program, noted that the preponderance of construction had gone into general hospitals, with relatively little into facilities for chronic and mental illness. Consequently, the act was amended to authorize earmarked appropriations for additional categories of facilities, all of which are more or less outside the usual scope of acute general hospital practice. These are nursing homes, chronic disease and rehabilitation facilities, and diagnostic and treatment centers for ambulatory patients.

Is this trend toward separate categorical facilities desirable? In many

Dr. Hoge is assistant surgeon general, U.S. Public Health Service. This article was condensed from a paper read before the joint session of the American Association for the Advancement of Science and the American Association of Hospital Consultants, New York, December 1956.

"Specialized hospital facilities have their disadvantages: they categorize people who refuse to remain categorized"

respects it is. The categories lend themselves more readily to the varying social, economic and medical patterns of the country than they do to the monolithic structure of the general hospital. The Hill-Burton amendments have had the effect of focusing attention upon these badly needed facilities and services. In two years, 100 chronic disease and nursing home projects providing 5273 beds have been approved under the program. In addition, 87 diagnostic and treatment centers and 45 rehabilitation facilities have been approved.

Separate and independent categorical facilities have their disadvantages too. They tend to break up the continuity of care. They categorize people who refuse to remain categorized. The acutely ill will become chronically ill, and the chronically ill will become acutely ill, and the slightly ill patient in the nursing home is likely to do either or both.

Is there any other way to cut this cloth to fit the pattern, to handle more of these problems within the general hospital? Perhaps there may be. I think we are beginning to see evolving within the general hospital a new concept of organization, administration and practice. This concept implies greater emphasis on segregation of patients according to the degree of illness, rather than the clinical nature of the illness.

INTENSIVE TREATMENT FACILITIES

Hospitals are engaged in the never-ending search for ways and means to provide better patient care. The search goes on in the face of increasing shortages of trained personnel, rising costs, and other discouragements and frustrations.

The current trend toward intensive treatment units is a forward step. These units focus and concentrate the resources of the hospital and its staff on the areas where the need is greatest. The result is improved patient care, better morale, and better utilization of highly trained but scarce personnel.

The commonest example of intensive treatment facilities is the postoperative recovery room. This is a relatively recent development that has come about, for the most part, in the past 10 or 15 years, and is now on the way to becoming standard in general hospitals with active surgical services.

The increasing extent and daring of surgical procedures is increasing the danger of postoperative accidents. These include the various manifestations of airway block, hemorrhage and shock. If these patients can be kept under close observation up to periods of 24 hours by nurses trained in postoperative procedures, most of the accidents can be prevented.

The new hospital planner will be confronted with some basic decisions very early in his planning program. The first will be whether or not to provide a recovery room and, if so, what the appropriate size should be. It is difficult to generalize in this area and careful study will be required. The pattern of surgical practice expected to be carried on will have an important bearing on these decisions.

The higher the level of surgical skill available, the more complex the operations will be, and the greater the need for the special facility. In hospitals of fewer than 100 beds, where operations are relatively fewer and less complex, economy may argue against the inclusion of these facilities. In hospitals of more than 100 beds, the assumption must be that recovery rooms should be provided.

Since the pattern of surgical practice to be carried on in the new hospital cannot always be predicted exactly, some rule of thumb governing the size of the facility must be adopted. Studies carried out by the Public Health Service in connection with the Hill-Burton program show that such a rule of thumb, based upon the number of operations performed, is about as follows:

Hospitals with one to four operating rooms need one recovery bed for each operating room, plus one. Five to eight operating rooms require one recovery bed for each operating room, plus two. Nine to 12 operating rooms need one recovery bed for each operating room, plus three.

CRITICAL CARE UNITS

Since the recovery room has proved a device of great value in providing better patient care, it is only logical that the same concept should be extended to cover a longer period of intensive care, after the patient has recovered from the immediate effects of anesthesia and surgical procedures, or while he is critically ill from other causes. In recent years we have seen this idea developing in a few hospitals throughout the country.

The critically ill patient has, of course, always received more or less special attention, as far as circumstances would permit. In large wards it has been customary informally to group the sickest patients nearest the nurses' station. In private rooms, the private duty nurse has long served as the standard solution to the problem of caring for the very sick patient.

Neither method has been completely satisfactory. Neither location, as a rule, has the necessary equipment for intensive care, nor does either easily lend itself to adaptation. The growing difficulty in obtaining special duty nurses, in addition to the cost of 24 hour duty, is rapidly eliminating this method of providing intensive care in most hospitals. The obvious answer is to collect the seriously ill patients into one place with specialized equipment and specially trained personnel.

There appears to be a good deal of variation in the philosophy of the critical care unit as set up in different hospitals. In some, it appears to consist largely of extensions of the recovery room concept with surgical patients in the majority and largely under the control of the surgical department. In others, there is a more even balance between surgical and medical patients.

In all such units, however, the ancient hospital tradition of clinical,

"More than 20 per cent of the patients did not need the level of care the facilities they occupied were designed to provide"

economic and sex segregation has largely gone by the board. Male and female, surgical and medical, private, semiprivate and ward patients are frequently handled side by side in the same unit.

Admission and discharge policies are vital to the success of the critical care unit. Admission practices differ among hospitals. In some, admissions may be made both directly and from other sections of the hospital, including the recovery room. In other hospitals, admissions are made to the critical care area only after studies of the patients' requirements are made elsewhere. The latter would seem to be the method of choice in most cases.

EFFECTS ARE WIDESPREAD

If the critical care unit is to serve its purpose, admission to the unit must not be delayed after it is determined that a patient requires intensive care. The higher cost reflected in an additional charge to the patient of $10 or $12 per day may act as a deterring factor, unless all concerned are alert to this possibility. This is particularly true since the attitude of insurance plans toward these extra charges has not yet, in all instances, been resolved. It is equally important, too, that patients be removed to the regular nursing units as soon as the need for intensive care is over.

The effects of a critical care unit extend throughout the hospital. It will, perhaps, have little effect on the number of beds needed in the regular nursing units. It should, however, have a considerable effect on the staffing pattern necessary to service these units. While it may require almost the full time of three special duty nurses to care for a critically ill patient over a 24 hour period in a private room, the same nurses can give better care to three or four such patients over the same period in the special unit. This should materially reduce the number of graduate nurses needed in the regular units and permit much greater use of practical nurses and nurse's aides. Theoretically, at least, the reduction in highly skilled personnel needed in the regular nursing units should more than offset the added cost of the intensive care unit. More experience will be needed to determine if this will prove true.

In view of the wide approval already given the critical care unit by doctors, nurses and patients alike, it is probable that most new general hospitals built from now on will include this feature. Experience with the critical care unit is still limited and much study is still needed in order to produce the best type of design and equipment.

Determining the proper size of the unit in any hospital will require careful study. Here, as in the recovery room, generalization will be difficult, varying with the type of hospital practice, the nature of the community, and so forth.

Where it is planned to set up a critical care unit in a going hospital, the problem of size should not be too difficult. A study of the case load over a period of a few months should give a fairly accurate picture of the number of patients who should be in an intensive care unit at any given time. Where new hospitals are being planned it will be necessary to check the experience of comparable hospitals, if possible. Present experience seems to indicate that, as an average, one intensive care bed will be needed for every 20 to 25 beds in regular nursing units.

SELF-HELP NURSING UNITS

Since there are special advantages to be gained in the segregation of the critically ill patient, may there not also be advantages in segregation at the opposite end of the sickness scale?

In a sense, this has been done for a long time. We have hospitals for so-called chronic or long-term illness. We have nursing homes, occupied mainly by persons of advanced age, who need only a minimum of medical and nursing care. Nevertheless, repeated surveys of patient loads in acute general hospitals have shown that 20 per cent and more of the patients at any given time were not in need of the level of care which the facilities they occupied were designed to provide. For the most part, these are not the types of patients who might otherwise be in chronic disease hospitals or nursing homes. Rather, they might be described simply as the less acutely ill. They include the convalescents, those in for observation and diagnosis, and those with other minor disabilities.

MINIMALLY ILL SEGREGATED

Since the acute general hospital is built around the needs of the more or less seriously ill patient, it has occurred to some that these minimally ill patients, too, could be segregated into units in which the level of nursing care and other services could be greatly reduced over that needed in the regular nursing units. By the same reasoning, if special units were built for such cases, the cost should be much less per bed than that of the regular general hospital.

Some such plan is now being tried out in several places throughout the country under various labels, such as self-help units, minimal care units, and progress units. Perhaps the term "self-help" is the nomenclature of choice. Basic to the concept of this type of unit is the principle that in addition to adequate care, or as a part of it, the patient shall perform for himself certain services which, under normal hospital circumstances, would be performed by others.

Last November the Secretary of the Department of Health, Education and Welfare appointed a committee, under the chairmanship of Dr. Russell Nelson, to study the possibilities of self-help units and make recommendations. It is possible that the findings of this committee may have an important influence on the future design, organization and administration of our general hospitals.

The division of nursing resources of

the Public Health Service has recently carried on some preliminary studies in this area on behalf of the Nelson committee. One fact revealed by these studies is that self-help units, while appealing to the experimental instincts of many hospitals, are as yet in very limited use throughout the country.

Another element of interest is the wide variety of concepts or purposes for these special units. In 12 different hospitals having self-help units, six different labels implying six different purposes were found.

It seems clear that the self-help unit has a place in the complete spectrum of hospital and medical care. If it contributes to the care of the patient, to the better utilization of hospital personnel, and to a better alignment of costs in relation to the needs of the individual patient, the effort necessary in this development will be worth while.

The problem is, however, exceedingly complex. Its solution will require a break with tradition in many areas, particularly on the part of doctors, nurses and hospital administrators. This, I think, is a fruitful field of study for the hospital planners, the consultant, the hospital staff, the administrator and the architect, and perhaps I should add, the insurance plans.

Form follows function, and we urgently need more information on what the function of the self-help and other types of units should be. We should follow carefully the progress of experiments now being carried on. We need more information on the medical and nursing needs of the patients in general hospitals.

$2,400,000 MADE AVAILABLE

Multiplied millions of dollars from both governmental and private sources are being poured into medical research. Each new discovery renders both our existing hospitals and our present concepts of hospital design more obsolete. Research both in the design and administration of hospitals must be speeded up if the findings of medical science are to be brought to bear with maximum effect on the cure of the patient. Although this field of research has too long been neglected, we are now getting started. In the last two years $2,400,000 for this purpose has been made available under the Hill-Burton program. More funds from private sources are becoming available for research in this field. There are now many worth-while research projects under way which should go far toward solving some of the problems I have discussed here. The hospital planners, the architects, and the administrators will soon be faced with the challenge of translating this new knowledge into ways and means of providing better care for patients.

Recovery Rooms Offer Safer and Better Care, Surgeons and Nurses Agree in Joint Session

NEW ORLEANS. — Organization of services in the postoperative recovery room was the subject of a panel discussion at a joint session for surgeons and nurses during a sectional meeting of the American College of Surgeons here last month.

Recovery rooms are expensive and do not cut down on the cost of patient care or help meet the nursing shortage, Thelma Laird, director of nursing at Memorial Hospital, New York City, told the group, but "recovery rooms do offer safer and better care for postoperative patients," she emphasized.

There is no established formula for staffing the recovery room, Miss Laird reported. Rather, she said, the number of nurses needed will vary according to the needs of the individual hospital; within the hospital, the recovery room staff must be flexible so that staffing may be adjusted according to the number of patients in the recovery room at any time, and the specific nursing needs of these patients.

Answering a question, Dr. Alton Ochsner of New Orleans, director of surgery at the Ochsner Foundation Hospital, differentiated between the postanesthesia room, where patients stay for only a few hours, and the postoperative recovery room, where the patient may remain for as long as three or four days. He also identified another type of facility—the intensive treatment ward, for medical and other critically ill patients.

Other subjects discussed by the recovery room panel were:

1. What patients should go to the recovery room?

All patients having anesthesia other than local, Dr. Ochsner said. The patient should remain in the recovery room until it is safe for him to be returned to his own room, in the surgeon's judgment. In the case of the postanesthesia recovery room, Dr. John Adriani, director of the department of anesthesiology, Charity Hospital, New Orleans, said the anesthetist is responsible but the time of discharge should be determined by both the anesthetist and the surgeon to ensure safety.

2. Should practical nurses be used in the recovery room?

There is no reason not to have some practical nurses, if their duties are clearly defined and they are carefully supervised, the panel agreed.

3. Should the recovery room staff be rotated?

The recovery room requires a specialized staff, and therefore rotation is usually inadvisable, Audrey Bell, operating room supervisor at Parkland Memorial Hospital, Dallas, Tex., told the group.

4. Who should supervise the recovery room?

The supervisory function may vary with the hospital, the staff, and the location of the recovery room within the surgical department, the panel agreed, but this duty usually falls to the operating room supervisor or a surgical nurse.

5. Does the recovery room supervisor need special training?

In addition to her training in surgical nursing, any course in supervision will be helpful to the nurse in charge of this unit.

6. Should private duty nurses be allowed in the recovery room?

Occasionally this is desirable, nurses on the panel acknowledged, but they stressed that patients are primarily the responsibility of the recovery room staff, and the general trend is toward elimination of private duty nurses from this unit.

7. May active tuberculosis patients be cared for in the recovery room?

Where proper isolation technics are used, this is permissible, Miss Bell stated. Some recovery rooms include special isolation sections, she added.

8. Are visitors allowed in the recovery room?

The practice varies with the area and the individual hospital, panel members reported, but ordinarily the

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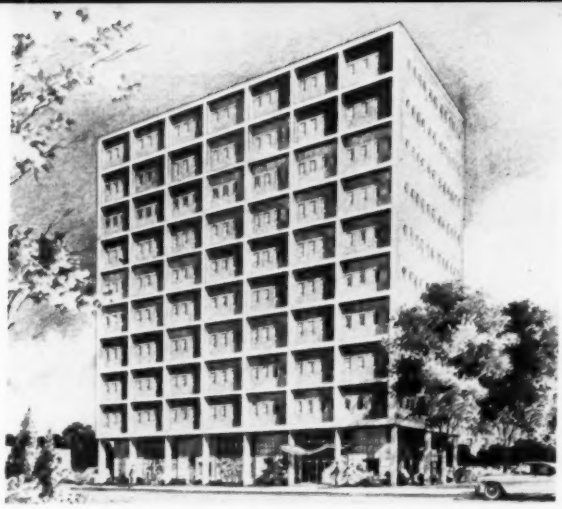

Architect's drawing of doctors' office building for Baptist Memorial Hospital, Memphis, Tenn., on which construction is about to start.

Private Office Practice in Hospitals

More and more hospitals are providing office space for staff physicians, according to this study by the Hospital Council of Philadelphia, which includes the views, pro and con, of hospitals with these facilities

C. RUFUS OREM

MODERN medical services involve specialized knowledge and skill, also extensive capital investment in apparatus and equipment. Hospitals represent a large portion of the facilities used for diagnosis and treatment by medical practitioners.

A significant development in the effective use of capital investment is the continuing growth of private office practice at hospitals. Independent physicians maintain offices for consultation, diagnosis and treatment of private patients who pay fees to the doctors for such services. Each doctor maintains a full-time or part-time private office in a building owned by or adjacent to a hospital. The special diagnostic and laboratory facilities of the institution are availed of by the doctors on behalf of their private office patients.

In a study being conducted by the Hospital Council of Philadelphia, through a grant from the National Institutes of Health of the U.S. Public Health Service, it has been determined that several hundred nonprofit community hospitals have established private office facilities for doctors on hospital property or in structures adjacent to hospital buildings. Preliminary data received from upwards of 100 institutions justify certain conclusions set forth in the present article.

Dr. Rorem is executive director, Hospital Council of Philadelphia.

Private office practice at hospitals may be contrasted with the provision of facilities for the convenience of full-time salaried staffs of medical schools or hospitals; also with examination and treatment rooms which are used intermittently by medical staff members and which are furnished by many institutions. This article also excludes consideration of hospitals owned by private clinics, whose members maintain offices at the institution.

Private physicians' offices have been found in both small and large institutions, ranging from facilities of three or four doctors in community hospitals of 30 beds or less to offices for several hundred practitioners at large metropolitan medical centers.

Offices are found in all parts of the United States, *e.g.* Boston, Hartford, New York, Philadelphia, Pittsburgh, Detroit, Chicago, Atlanta, Memphis, Shreveport, Houston, Denver, Los Angeles; also in many smaller cities such as Princeton, N.J., Kalamazoo, Mich., and Rockford, Ill. At some institutions only a small proportion of the attending physicians are accommodated. In others most of the staff are installed at the hospital.

A majority of these hospitals originally established the private offices by remodeling or renovating a section of a building originally designed for other purposes. Illustra-

Above: Clinton Street Building of Pennsylvania Hospital, Philadelphia, has three floors of offices.

Above: Typical example of 17 suites assigned to doctors at Pennsylvania Hospital, Philadelphia.

"Our objectives for the most part have been realized. Advantages not originally foreseen include combined purchasing of supplies resulting in lower unit cost; a larger plant over which to spread the cost of maintenance employes; equipment duplicated in the clinic that can be used as an auxiliary by the hospital."

tions of such arrangements are found at the Children's, Abington, Episcopal and Pennsylvania hospitals in the Philadelphia area.

At one large eastern hospital a new patients' pavilion constructed in 1931 contained a number of private rooms which were not utilized to reasonable capacity. In 1932, members of the medical staff were invited to lease a part of these facilities for a temporary period at modest prices. Thirty accepted. The advantages to the doctors and patients led to the continuance of the arrangement, and 35 additional patients' rooms were converted to private offices. During the last 25 years, the hospital has expanded its bed facilities and diagnostic services. But the doctors' offices are still used for private practice.

Recently, expansion programs at a number of hospitals have included private office facilities for staff members on one or more floors. Illustrations are the Toronto Western Hospital, Lankenau and Episcopal hospitals in Philadelphia, LeBonheur Children's Hospital in Memphis, and the Wesley Memorial in Chicago.

The Lankenau Hospital, originally established in 1860, moved from a mid-city location to entirely new facilities in a suburban area in 1952. Offices were provided for a total of 47 active members of the medical staff. The suites were leased before construction was finished, and many of the doctors discontinued their downtown private offices because of the convenience of the new and modern suburban facilities.

Some hospitals have made private offices available through the renovation of adjacent buildings which had been originally constructed for other purposes. In 1943 the Pennsylvania Hospital in Philadelphia purchased an office building originally constructed to house a group of social agencies, located across the street from other hospital property. The building now contains the private offices of 30 medical specialists who are members of the hospital's attending staff. The structure is connected by a tunnel to other hospital buildings and to the departments for diagnosis and treatment.

Separate buildings for private physicians' offices have been constructed by or near a number of community hospitals. One of the first was erected in 1929, by the Baptist Memorial Hospital, Memphis, Tenn. The building is now used by 100 members of the attending staff of that hospital, which is located in a "medical center" area of the city. The building has been occupied to capacity since its erection, and plans have been drawn for an additional office building to be finished this year.

At Hermann Hospital, Houston, Tex., a doctors' office building for 90 physicians was constructed in 1949. A portion of the hospital's endowment funds financed the construction costs, and all revenue has been applied to financing free service at the Hermann Hospital.

Other more recently constructed office buildings at hospitals have been erected by the Princeton Hospital, Princeton, N.J., and the Monmouth Memorial Hospital at Asbury Park, N.J. During 1957 separate buildings will be completed for 28 physicians by the Rockford Memorial Hospital, Rockford, Ill.; for 18 doctors at the Willis-Knighton Memorial Hospital, Shreveport, La., and for 100 staff members at the Baptist Memorial Hospital, Atlanta, Ga.

Some of the physicians' private office buildings adjacent to hospitals have been erected as commercial ventures, with the property owned by partnerships, insurance companies, or real estate operators. Such a building for 120

doctors was constructed near the Hartford Hospital, Hartford, Conn., and is owned by an insurance company.

The Bryn Mawr Medical Building, Bryn Mawr, Pa. (46 doctors), is a stock corporation. It is constructed on land purchased from Bryn Mawr Hospital. The project is administered by a management committee of five persons, three represented by the real estate firm which furnished the capital and which holds the legal title to the property, one selected by tenants of the building, and one by the hospital. The hospital must approve all physician-tenants accepted for occupancy of the offices unless one-third or more of the facilities are vacant.

Tenant-physicians in private offices pay established rentals to the hospital or the corporation providing the offices, usually in monthly installments. Rental charges are approximately equal to the going rates for similar accommodations in the metropolitan or trading areas. A suburban building may, of course, command rentals somewhat lower than similar facilities in the central portion of a large city. Monthly rentals generally include utility services, such as heat, light, water, electric power and air conditioning.

Typically, annual rentals are based on the floor space of each office, regardless of location or number of physicians who utilize the office accommodations. But in some buildings, differentials have been established for the more desirable locations, also for offices or suites used by two or more physicians.

Some offices are used by several physicians, each of whom maintains a private office in another part of the city. Each doctor may be charged on the basis of the number of sessions or hours the office is used, or the number of patient-visits. The time unit basis has been applied successfully at the Abington Memorial Hospital, Abington, Pa., and the Columbia-Presbyterian Medical Center, New York City. The visit basis is used at the Columbia Hospital, Milwaukee, Strong Memorial Hospital, Rochester, N.Y., and the Chicago Wesley Memorial Hospital.

There is wide variation in the form of lease agreements. Commercially-owned office buildings, and others recently constructed, tend to require formal lease agreements setting forth in detail the rights and obligations of the doctors and the institutions.

Some of the hospitals which have established offices in remodeled facilities have conducted the programs without formal written leases. A short letter of agreement may be signed by the doctor and the institution, stating the rental charges and the period of notice necessary for cancellation.

In a number of cases no written agreement, even in letter form, has been developed. The entire activity has been carried forward on the basis of an oral understanding between the hospital management and members of the attending staff.

Certain problems arise in determining which doctors will occupy a group of offices which are insufficient to accommodate the entire attending staff. Usually doctors are given original priority on the basis of their rank and length of service on the staff. After the initial assignment of space, new tenants are accepted in the order of their applications.

At some hospitals an attempt is made to establish and maintain a balance of professional specialties among the occupants of the private offices. For example, an internist or pediatrician might be given priority when a vacancy occurs, if these specialties had not been well represented among the other tenants of offices.

Occupancy of private offices at hospitals appears to be

"The doctors have a greater tendency to recognize needs of the hospital for equipment and other facilities and are therefore more inclined to offer support and encourage the support of others."

"Having physicians' offices presents some disadvantages. Some physicians seem to assume that, since they have offices in the hospital, they have a right to become involved in purely administrative matters."

Below: The lobby of the Bryn Mawr Medical Office Building, Bryn Mawr, Pa., looks like a private home.

Exterior of Bryn Mawr office building which is presently occupied by 45 physicians and one dentist.

"Ground floor space has been leased to a pharmacy, flower shop, optical shop, camera shop, and the local office of the Blue Cross plan. The top floor is a hotel unit with twenty-six rooms, designed to accommodate ambulatory patients of physicians in the building and relatives of patients in the hospital. This hotel unit started slow, but is now making money."

Below: Paterson General Hospital, Paterson, N.J., provides offices such as this for medical staff.

Below: Present physicians' office building, Baptist Memorial Hospital, Memphis, houses 100 doctors.

most popular with surgeons, obstetricians and other specialists who hospitalize a high percentage of their private patients. There is usually less interest on the part of pediatricians, psychiatrists and dermatologists.

Some doctors who maintain private offices at a hospital also conduct practice in other locations. But many doctors with "downtown" offices ultimately relinquish them to conduct all practice at the hospital, thus saving time for themselves and their patients. It is not customary for a hospital to require a tenant-physician to discontinue other private offices in the community.

It is important that lease agreements specify the terms of cancellation. Most private offices at hospitals are available only to active members of the attending staff. In at least one instance a physician-tenant refused to surrender his office after loss of a staff appointment, inasmuch as the lease for his office had not expired.

Tenant-doctors seldom conduct extensive laboratory services in their offices, but prefer to use the facilities of the institution for this purpose. Occasionally an internist will install a previously purchased fluoroscope in his hospital office, with the understanding that it will not be replaced, also that no radiographic equipment will be operated in the new office.

As a general rule tenant-physicians refer their private patients to the various hospital departments for specialized diagnostic and treatment facilities. One hospital maintains a small laboratory for the benefit of tenant-physicians in space which the hospital leases from the commercially-operated adjacent building. Another maintains a special messenger service for the collection of specimens and distribution of laboratory reports for the benefit of tenant-physicians.

Minor operating rooms are not permitted in the offices of the physicians, who are expected to use the general operating and delivery room facilities of the institution. Likewise, space may not be rented for purposes of conducting basal metabolism tests or for electrocardiography.

At one hospital the tenant-physicians are required in their lease agreements to refer all diagnostic and special treatment cases to the hospital from which the office facilities were rented. In most instances such obligations are limited to an agreement not to conduct these services in their private offices. All of the hospitals which maintain private offices conduct pharmacies at which doctors' prescriptions may be filled at prices similar to those charged in local drugstores.

Tenant-physicians, as a general rule, assume no obligations for the care of hospital patients which are not required of other active staff members. They are expected to assist in the care of emergency cases and to provide staff service to inpatients who cannot pay attending physicians. But tenant-physicians are often more accessible than other doctors in case of emergencies. Likewise, they tend to be members of the senior attending staff, who would normally carry considerable responsibility for education, research and community service.

Physicians tend to concentrate their inpatients at the hospitals where they maintain offices, even though they may have staff privileges in other parts of the city. Some have been known to discontinue the care of inpatients in all other institutions, once they have become accustomed to seeing their private office patients at a hospital.

Tenant-doctors indicate the following advantages of maintaining full-time offices at a hospital. Travel time be-

tween office and hospital is avoided. Daily "rounds" are more easily scheduled. Office appointments may be interrupted for emergency attention to a hospital inpatient. Postoperative care is more easily supervised. Many patients, particularly children, become less apprehensive over inpatient service after they have visited a hospital as office patients.

Senior medical staff members have mentioned that a hospital office conserves their time in the supervision of residents and the teaching of interns, medical students and the nursing staff. One physician mentioned that since he has established offices at the hospital he less frequently recommends private duty nursing service for his patients, since he is more readily available for consultation.

Many patients prefer to visit their doctor at a hospital rather than a residential office or a downtown office building. Some assert that a hospital call is relatively anonymous and therefore more satisfactory. Others stress the advantages of a one-stop shopping center for medical care, particularly when diagnostic procedures are prescribed by the attending physician. Some believe that a doctor tends to be more available at his office at the hospital, even though elsewhere in the building at the time of a patient's arrival.

Establishment of a new office at a hospital has all of the advantages and limitations of changing to any other location. Certain patients will prefer the new address; others will object to it.

Hospitals located in "undesirable" sections are not particularly suitable for private office practice. A patient may be willing to go to any location for a single episode of bed care, yet resist making a series of office visits before and after hospitalization.

Some administrators believe that the continued presence of a physician at a hospital gives him a better understanding of hospital management than could be obtained from occasional visits to attend inpatients. The increased number of visits to patients' rooms during periods of emergency tends to acquaint them with the services of nurses, technicians and other paramedical personnel.

Doctors' offices at hospitals make it easier for administrators to contact them regarding staff policies and procedures. Committee meetings may be called without requiring each physician to make a special trip to the appointed place.

Where has the money come from to establish physicians' private offices at hospitals? In general, minor alterations have been financed from current assets of the institutions. These amounts may range from $10,000 to $100,000.

The capital investment for offices established in newly constructed facilities, whether separate buildings or special floors, may range from $200,000 upward, depending on the number of office suites made available. Some hospitals have invested unrestricted endowment capital in these facilities. Others have obtained loans from banks or insurance companies. Some of the buildings are, of course, operated strictly as business enterprises.

It appears to be legally permissible for endowment capital to be applied to the construction of doctors' offices which are productive of revenue to the hospital, and which are protected by the general credit and assets of the institution.

Private medical practice is not a charitable service from the legal point of view. Accordingly, the capital investment devoted by a nonprofit hospital to private office facilities has, in some cases, been ruled as subject to real estate taxes

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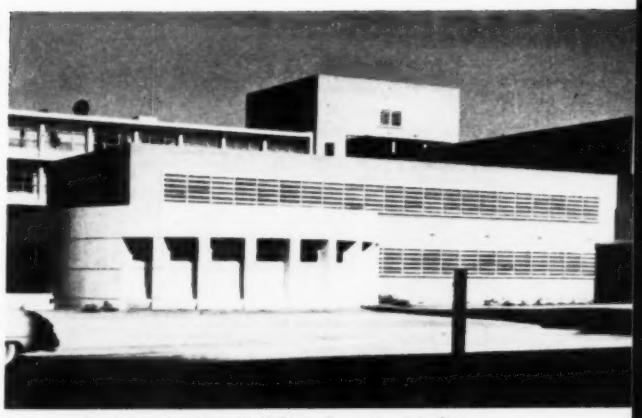


Above: Physicians' Office Building, housing 16 doctors, Le Bonheur Children's Hospital, Memphis.

Above: This wing of Lankenau Hospital, Philadelphia, has office accommodations for 57 doctors.

"Throughout the years, there have been many difficulties as a result of the hospital's renting offices to a group of surgeons. These surgeons were the first to ask for and obtain such offices at the hospital. Later, internists and general practitioners complained that they were being discriminated against and that, in addition, patients with complaints other than of a surgical nature were being treated by surgeons who were occupying offices within the hospital."

These Hospitals Are All in Favor of

"The Doctors Are Very Happy Here; They Can See Their Patients Easily"

J. A. GILBREATH
Administrator, Arkansas Baptist Hospital
Little Rock, Ark.

Baptist Medical Arts Building, Little Rock, Ark.

ARKANSAS Baptist Hospital at Little Rock had two goals in planning for a medical arts building. The first was to build a nucleus of physicians around the hospital who would use our beds and be immediately available for call when their patients were in need of medical attention. The second was to provide finances for the future in order to help in operating the hospital.

When the building was completed we found some opposition from the doctors to moving into the units because they belonged to two staffs and thought they might be identified with only one staff, which would be a detriment to their practice. This position prevailed for some period of time and it was necessary for the hospital to rent its facilities to persons other than doctors. We now rent about a third of the space to physicians and two-thirds to commercial companies.

Therefore we have not been successful in getting enough doctors into our building. However, those who do have offices here are very happy, particularly in the amount of time that they are able to save traveling from office to hospital and because their patients can be seen more easily.

We do believe that the building is successful financially. From the income paid for the office space we are able to maintain the building, maintain depreciation, and make the annual payments on the building. At the end of 15 years the building will be completely paid for and the money will go into the operation of the hospital.

On the ground floor of the Medical Arts Building we have a coffee shop and drugstore and the annual net profit from these departments is a great help in meeting financial needs of operating the hospital.

The Medical Arts Building is located immediately behind the hospital with only a street between the two buildings.

Our building cost was $683,176.60. This included only bay partitions, lighting, flooring and painting. Each doctor was responsible for his own partition work and other equipment. In most instances our own construction crews did the actual work for the doctors but the physicians were responsible for the cost. The hospital financed this building with a half-million dollar loan from an insurance company at a 4 per cent interest rate.

At the present time we have 16 physicians in our building. Olin Mathieson Chemical Company rents about half of our entire space. In addition, we have the Retail Credit Company and several insurance companies. As some of these companies move out we are renting to doctors and hope eventually to rent the entire building to physicians.

Our income per year on rents is $90,000. Our payments on the loan amount to $44,000 annually. Our total direct expense for the year was $39,517.57. Indirect expense charge was depreciation, maintenance and administrative expense and amounted to $26,914.02. We charge $3 per square foot.

The rental department of a local bank is responsible for our building. We feel this keeps us out of arguments with our physicians and think it is well worth the collection expense.

"The Physician Has the Privilege of Designing His Own Office Layout"

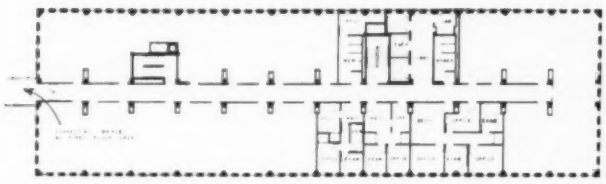
EDWIN B. PEEL
Administrator, Georgia Baptist Hospital
Atlanta

THE Baptist Professional Building, Atlanta, Ga., was planned to be an endowment operation well integrated in the total hospital picture of patient care. The necessity for financial planning in developing programs of patient care in the community makes this venture possible and desirable. Ours is a seven-story and basement building which will accommodate approximately 100 physicians and dentists when completely filled, plus commercial shops. The following is a breakdown of floor space:

Floor	Gross Sq. Ft.	Net Sq. Ft. Rentable
Basement	12,168	7,293
Ground	12,168	8,655
Six Office Floors	73,011	52,830
Totals	97,347	68,778

Our rental rate is $4 per square foot per year. The building is of modern construction and completely air-conditioned, and the rental rate is comparable to that found in other

Doctors' Offices Attached to Hospitals



Typical plan of Professional Building, Atlanta.

Baptist Professional Building, Atlanta, Ga.

office buildings in this area. Also, the physician has the privilege of designing his own office layout.

With the usual occupancy rate experienced by other buildings of this type, the original loan commitment should be amortized in 17 years.

Having a professional office building close to the hospital has its greatest advantage to the patient inasmuch as the physician is readily available when needed. The physician himself has the advantage of convenience since the majority of his patients will probably be in this hospital. (Not all tenants are on our staff.) Because of time saved in commuting to and from the hospital to see patients, a physician in the building may actually increase the number of patients he is able to see per day enough to realize an appreciable increase in income.

"The Avoidance of Duplication of Both Equipment and Personnel Saves Expense"

M. E. ROBBERSON Jr., M.D., and EDWARD T. SHIRLEY, M.D.
Robberson-Shirley Hospital, Wynnewood, Okla.

I BEGAN the practice of medicine with my father in 1936, and the following year we established a 14 bed hospital on the second floor of a downtown business house. For 10 years we rented this space and operated the small plant successfully. In 1947 Dr. Edward T. Shirley came in with us and we began to plan for a hospital building and clinic of our own. A clinic and 26 bed hospital, combined, was built and occupied Jan. 1, 1951.

Experience had taught us there was a great advantage in having office facilities and hospital in close proximity. We had decided that we wanted the clinic portion and the hospital to be joined and yet have two separate working units, and I think the final results have been quite successful.

In our general practice, we are constantly in demand from the hospital force to care for obstetric patients, emergencies or acute patients. We can see them on a moment's notice, whereas if the units were widely separated or across town there would be a great deal more lost time and travel. The business office which is located between the two units does the work for both the clinic and the hospital. This allows for only one record; however, the results are separated so a check can be made on each.

It is my impression that the rentals we had paid in the original hospital paid for the entire building during our occupancy. That being the case a proportionate rental paid here would build the area occupied for clinic or hospital on the same basis. From the standpoint of heating, cooling and other utilities, I believe it is more economical than having separate units. Custodial or janitor service in both units is handled by the same personnel.

We are in direct contact with the hospital at all times through our own telephone switchboard. The dictating facilities are handled through the business office and can be used at the nurses' desk of the hospital as well as our office desks.

In summary, I would say the convenience for the hospital and the doctors, the elimination of duplication of personnel, the economic savings under one utility service, the combined use of diagnostic and treatment equipment, the one business office for processing accounts and buying far outweigh any bad features that might be considered.

Our aim when we built the hospital was to get a combination of examining and treatment rooms, diagnostic laboratory and x-ray services, and hospital facilities all on one floor and under the same roof. Doors between offices, as well as into corridors, private entrance and exit for doctors, and passageway to the hospital through the x-ray room have greatly lessened annoying casual contacts with the public.

The reduction of travel time from office to hospital, especially when keeping an obstetrical vigil, is the most advantageous feature of the setup. The avoidance of duplication of diagnostic and therapeutic equipment and personnel saves expense. The availability of the building 24 hours a day has educated the patients to go there instead of calling us after hours, and saves many night calls.

ROREM—PRIVATE PRACTICE

(*Continued From Page 59*)

by local governments. Several of the hospitals have brought their problems voluntarily to the attention of the taxing bodies. As a result, the assessed values have been conservatively established to limit the financial burden upon the nonprofit institution. Hospital trustees and administrators assert that the indirect financial values of physicians' private offices are much greater than the taxes which have been assessed against the institutions. Assessments have been applied only against the estimated value of those portions of a hospital devoted to private office practice.

No instance is known where the provision of private offices by a nonprofit hospital has caused the institution to become subject to federal income taxation upon either the rentals of private offices or other earnings of the institution. Conversely, at one institution a federal tax investigator was concerned that the hospital charge sufficient rentals against the tenant-physicians. Unduly low rentals, he argued, might create a situation in which the earnings

Disadvantages of Doctors' Offices

"The Doctor Is Considered an Employe of the Hospital by the Community"

ALLEN E. LEARY
Administrator, Santa Rosa Hospital, Milton, Fla.

IT HAS been my privilege to have administered two hospitals which had adjoining physicians' offices. One was a small proprietary hospital and the other is the 30 bed county institution of which I am presently administrator. Both types of operation offered many problems and each has problems peculiar to its organization.

The proprietary hospital had four private offices. The medical staff was closed and under constant surveillance of one of the physicians who owned the hospital. Many differences existed among them as to whom the receptionist should refer a new patient. The physicians kept constant pressure on the business office of the hospital to effect collections for them before the patients were discharged. This caused a great deal of accounting not normally found in other hospitals.

It was next to impossible to control hospital supplies so the cost of operation was increased. Had the offices been in a separate building I believe that the relationship would have been more beneficial and harmonious.

In the county hospital four offices were located just off the main lobby. The original plan called for three small medical offices and one dental office. The dental office was not needed and was enlarged for the first physician to enter practice in the hospital.

It was the desire of the board of trustees to make available suitable office space at a modest rent to encourage young physicians to move to this rural community. For this purpose, at least, it has served well.

Many factors must be examined if we are to determine the advisability of such an arrangement. While there are some advantages it is our considered opinion that the disadvantages to both the physician and the administration far outweigh the advantages.

The doctor with an office in the hospital has an advantage over the physician located elsewhere in obtaining new patients. This is considered by some as an unwholesome situation. Furthermore, the physician whose office is in the hospital is considered by the community to be an employe of the hospital and therefore not due the fee of a private physician.

The lobby of our hospital is used as a common waiting area for the doctors with their offices in the hospital. The doctors have no means of entrance or exit other than through the lobby, which in turn exposes them to all who want their services. The examining and consultation rooms are one and the same and the physician must step out in the lobby while the patient is prepared for examination.

There is intermingling of office and hospital personnel, with the usual conflicts resulting from the varied interests of the two groups. Of course the time of both the physician and the administration is required to settle the misunderstandings.

Economically the arrangement is not practical. The office rentals are low and they include lights, heat and full housekeeping. The doctors and their employes are not in the least cost conscious and leave lights and air conditioners turned on after hours. The demands on the housekeeping department are many and often unjustifiable. No effort is made by the doctors' office staffs to straighten the lobby or the offices; they consider that these areas belong to the hospital and that it is the duty of the hospital to maintain them in a presentable condition. The lobby is a matter of concern to the administration. It is next to impossible to keep it picked up and in a condition comparable to the rest of the hospital. Bottles, candy wrappers, magazines and newspapers are always scattered about.

The business office of the hospital is kept busy answering the telephone and the questions of the cashier with regard to private patients who want to make appointments or payments. There should be one additional office employe to accommodate the private patients. The public is under the impression that the hospital should know the exact whereabouts of the doctors at all times. This is especially true of the doctors who maintain their offices in the building. Furthermore,

of the institution would inure, in part, to the financial benefit of private individuals, namely, the doctors.

Broad conclusions must await further study of the administrative, professional and social aspects of private office practice at hospitals. Preliminary findings indicate that the trend has resulted in effective utilization of the time of professional men and their office patients. It has also reduced costs of private practice by limiting the capital investment required for complete diagnosis and treatment. Hospital scientific facilities and personnel have been utilized to a greater degree, and attending physicians have more easily kept in touch with their bed cases after hospital admission.

It is essential that no improper professional or financial advantages be enjoyed by occupants of private offices at community hospitals. Likewise, the economic advantages of the arrangement should be shared with the patients who receive service and the public which provides the facilities. In the long run, this movement must be evaluated according to its effect upon the quality of medical care.

Outweigh All of the Advantages

"Problems Are Created Between the Doctors' Nurses and Hospital Nurses"

EARL E. CARY
Administrator, Okeene Municipal Hospital
Okeene, Okla.

THE Okeene Municipal Hospital is a small (21 bed) hospital built under the Hill-Burton program by the town of Okeene, Okla. Okeene is a small town having a population of 1200 inhabitants but the hospital serves a rather large area. The hospital is operated by the town of Okeene and has been in operation for five and one-half years.

The planning board's reasons for adding doctors' office space to the hospital facilities were threefold.

1. The town did not have adequate office rental space for doctors.
2. Such space would be an added attraction for doctors to locate in the community.
3. It would be a source of income for the hospital.

The hospital opened with a medical staff consisting of three doctors who were housed in space planned for only two so that it was inadequate from the onset. After a year of operation, one of the staff doctors died, relieving the congestion in office space for a few years. At this time the two remaining doctors need to expand their office space and are making plans to move out of the hospital, as the hospital cannot give the additional space desired.

There are some advantages in having doctors housed in our hospital: (1) The doctors are able to attend critically ill patients between outpatient office visits. (2) They are available in emergencies. (3) The doctors are in close contact with the patients and nursing staff. (4) The rent is an additional source of revenue. The last is of least importance in my opinion as the net income is small after direct and indirect expenses.

Some of the disadvantages of having them housed in the hospital are: (1) Administration problems between the doctors' office nurses and the hospital nursing staff are created. (2) Problems arise from use of hospital supplies, drugs and equipment by the medical staff members and their nursing personnel. (3) Most important, in my opinion, is that it virtually makes for a closed medical staff. It is not likely that other doctors would locate in this community and compete with the doctors housed in the hospital.

In summary, I will say that the disadvantages outweigh the advantages. The only important advantage in this small hospital, in my opinion, is the source of revenue from outpatient laboratory services from the doctors' offices. Since our average occupancy is only approximately 54 per cent inpatients, the outpatient laboratory income has offset the inpatient operating loss.

My opinion is based on 36 years of hospital experience in three hospitals of 300, 100 and 21 bed capacities, two of which had doctors' offices or clinics located in the house.

parking has become an increasing problem as both the hospital visitors and the physicians' patients use a common parking area. The number of cars has increased greatly and the patients have now started using our lawns and emergency drive for parking. This complicates the entrance of emergency vehicles and exposes the hospital to criticism.

The physicians have developed the habit of referring their office patients to the emergency room for routine medications on holidays and week ends. This has complicated the efficient operation of the nursing department inasmuch as we operate on a reduced staff on week ends and holidays. At such times it is not uncommon for a doctor to ask a floor nurse to assist him in the examination of a woman patient.

On many occasions where a difference has existed between the administration and an employe, the employe has sought the support of one of the physicians with offices in the hospital and the doctor has voiced an opinion in the matter, which only complicated the affair. We believe the doctor has no place in the internal affairs of the hospital and is placed in a most undesirable position when an employe seeks his aid.

After due consideration and experience in this operation the doctors have elected to vacate their hospital offices at the earliest possible moment and construct offices just adjacent to the hospital proper. We all feel that this will materially benefit all concerned.

A Factory Makes a Functional Hospital

Open floor areas, fireproof construction, wide masonry enclosed stairways, and ample space for economical nursing units made it fairly easy to convert this cigar factory into a hospital

LOUIS and HENRY MAGAZINER

EARLY in 1953, the Metropolitan Hospital of Philadelphia, an osteopathic institution, was advised by the commonwealth of Pennsylvania that it was exercising its right of eminent domain and that it intended to raze a number of buildings, including those of the Metropolitan Hospital, to make way for the Vine Street expressway. The hospital had to act quickly and decisively. It had neither the time nor the money to build a new structure but it had to move, and it wanted to expand at the same time.

The authors are architects, Philadelphia.

The purchase and the rehabilitation of some existing Philadelphia structure was decided upon. Some 40 buildings were examined. Starting with the obvious, first hotels and apartment houses were considered. But corridors were too narrow, stairs were inadequate, and prices were high. Then office buildings were considered.

Finally it was decided that a factory structure, which would cost the hospital least, would be the most economical. Here the hospital would not be paying for facilities which would have to be demolished to convert the building to its new use. Of prime importance were open floor areas which would convert easily into nursing rooms, the building's standing free of other structures so that a maximum number of windows could be provided, fireproof construction, wide masonry enclosed stairways at either end, floors large enough to provide economical nursing units, and the location easily accessible to patients and staff.

The architects made preliminary layouts for about 10 buildings and finally it was decided that the structure at 300 Spruce Street, a former cigar factory

Far left: In its previous incarnations the Metropolitan Hospital, Philadelphia, was a cigar factory and then used by the needles trades. The entire exterior was left just as it had been when it was remodeled for use as a hospital (left) except for the removal of all factory sash and the substitution of brick panels in some instances where windows were no longer needed and of aluminum sash in other instances.

Above, left: Batteries of sewing machines and spools of thread occupied the areas now devoted to the hospital laboratory. Center: Here is a section of the pharmacy. Counter tops are laminated plastic except near the sinks where stainless metal is used. Wainscot is glazed structural tile, with block walls above. Right: As the laboratory looks today. Here are performed hematologic and serologic examinations, also blood banking technics and specific tests on whole blood and serum. Counter tops are acid-resistant asbestos composition; wainscots are salt-glazed tile, and floors are made of asphalt tile blocks.

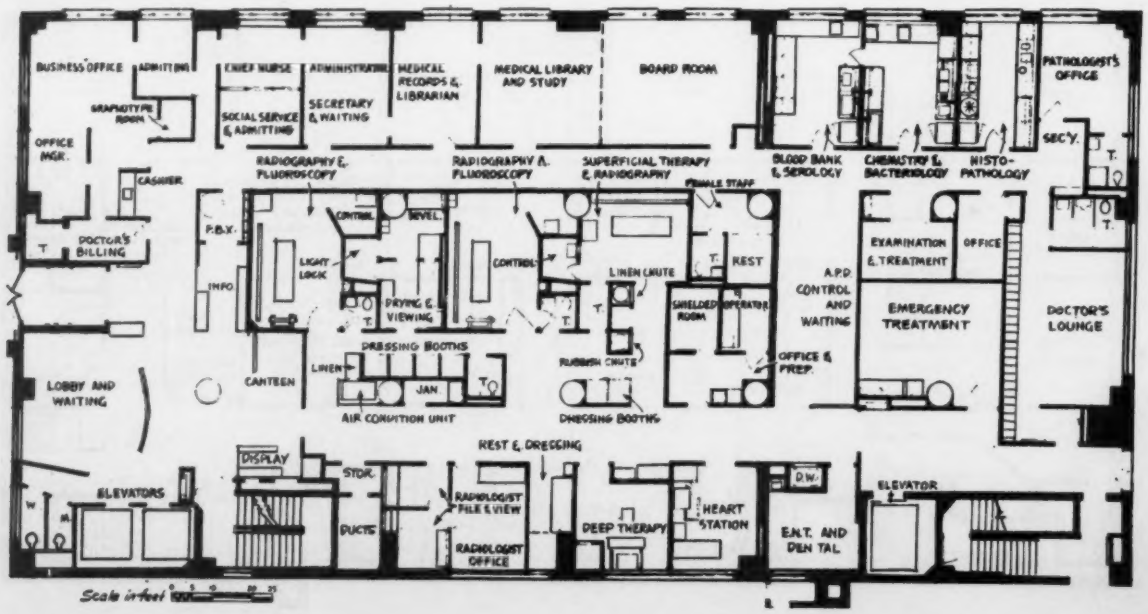
The inside of the hospital changes abruptly from the pseudo-Colonial of the exterior to a completely modern treatment. In the main lobby, part of which is shown here, walls are birch paneled, floors are marble terrazzo, all furniture is covered with plastic simulating woven fabrics. Ceiling is acoustical plaster.

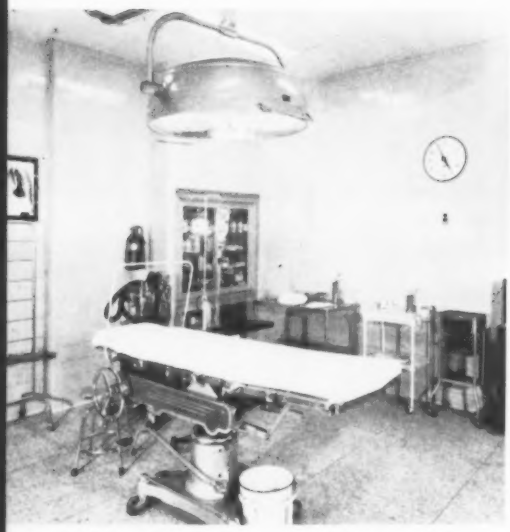
which was being used by the needles trades, would lend itself most readily to the projected use. Consideration was given to the fact that the Hospital of the Philadelphia College of Osteopathy is in West Philadelphia with a branch in North Philadelphia. Thus the location at 300 Spruce Street would provide a modern osteopathic hospital for South Philadelphia and Central Philadelphia and give the city a better distribution of osteopathic facilities.

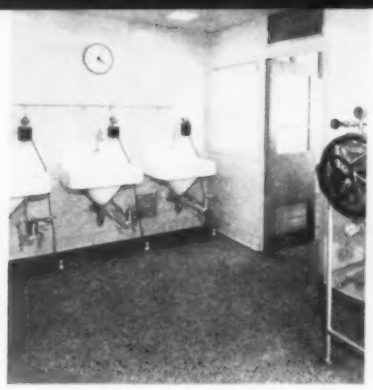
The hospital immediately purchased the building, and plans were put under way to reconstruct it and to finance the project. Louis and Henry Magaziner, architects, of Philadelphia and Isadore and Zachary Rosenfield, hospital consultants, of New York were commissioned to handle the design. In spite of existing limitations, they were able to plan (1) an outpatient service integrated with admissions, laboratories, x-ray, emergency and heart stations on the first floor; (2) delivery and operating departments sharing direct access to central sterile supply, yet having the entrance route to delivery satisfactorily separated from the entrance to surgery; (3) nursing units of economical size using the Blue Cross approved six-bed rooms, which fit perfectly into the existing column layout. Frequently, even new structures cannot achieve all these features.

To finance this project there is a bond issue of $600,000, of which the doctors subscribed to $500,000. A mortgage was obtained for an additional $600,000. The balance of the funds was gained from the sale of the old buildings to the commonwealth of Pennsylvania and from cash on hand. **(For additional pictures and plans, see next two pages)**

FIRST FLOOR





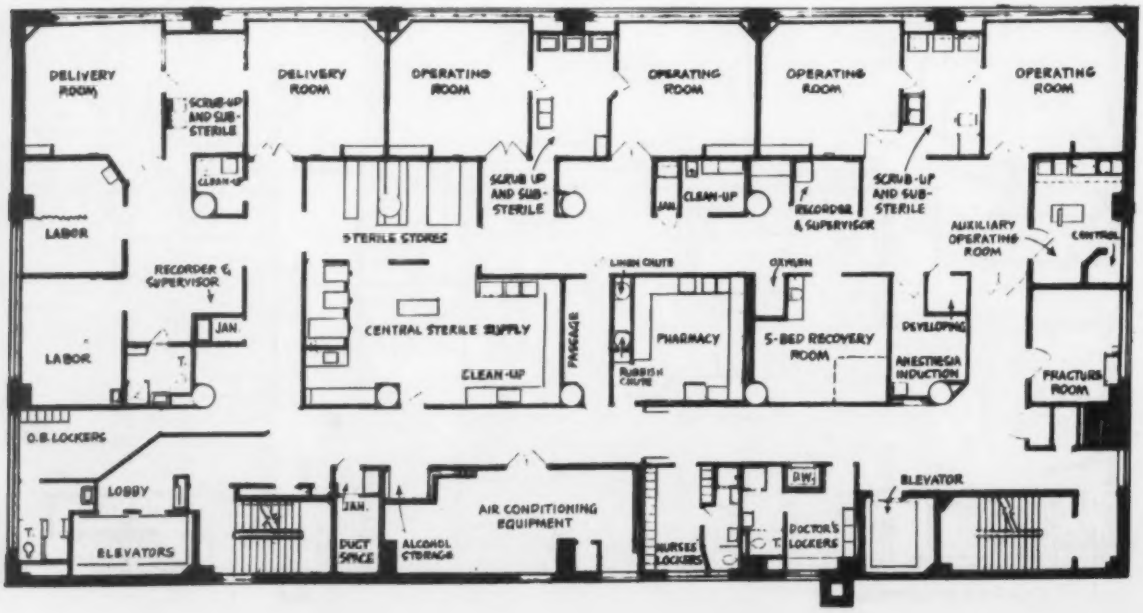


Left: A typical operating room. The walls are of glazed structural tile to the ceiling; floor is conductive terrazzo. A minimum number of explosionproof electrical receptacles are provided but wiring economy was effected by moving x-ray view boxes and additional electrical receptacles up above the explosion danger line. Vacuum and oxygen are provided. Center: Scrub-up and sub-sterilizing room. Sterilizer is a 5 minute, high pressure unit. Sinks are completely nonsplashing. Right: Needle workers plied their trade where surgery is.

Above, left: Kitchen is set up for delivery of food to nursing floors by electrically heated food trucks. The dishwashing area is shown in extreme right background. Deep fat fryers (at right) are spaced far apart for ease of cleaning.

Above, center: The cafeteria is in a basement room with no natural light so special attention was given to color treatment. Walls are painted warm gray; chairs are in bright, varied colors. Right: The kitchen area "before."

SECOND FLOOR

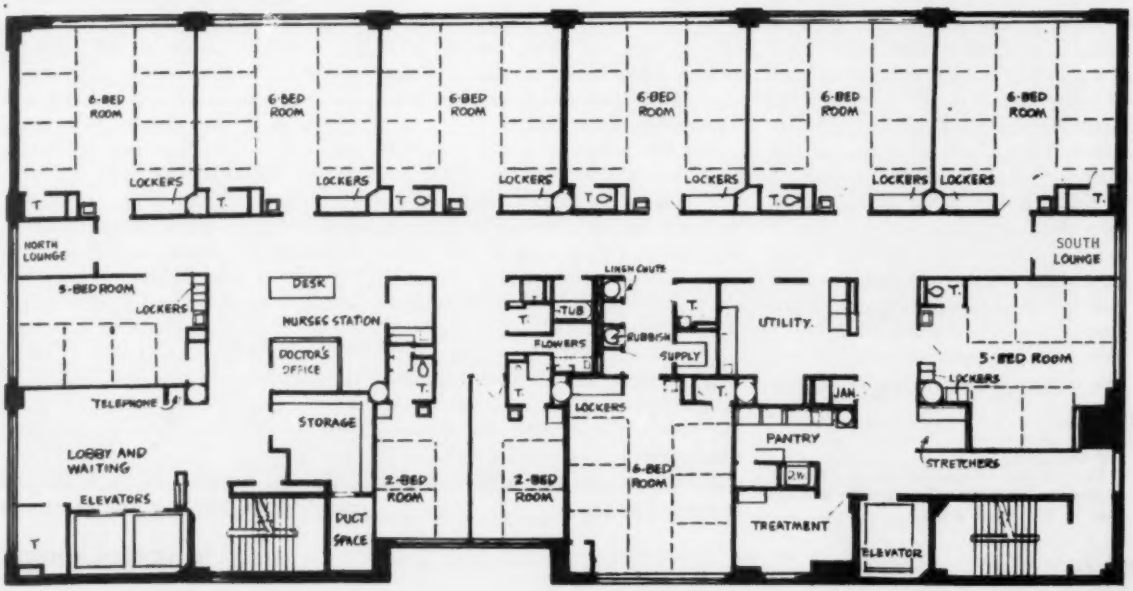


Above: Typical nursing room. Six services are available to each bed: (1) Incandescent light with adjustable downward component under patient's control, upward component controlled from door, and convenience receptacle; (2) wall-mounted convenience receptacle for apparatus; (3) nurses' call; (4) oxygen; (5) telephone, and (6) television pillow speaker receptacle. Each room has a silent television set visible to all bedridden patients.

Above: Long cutting tables, piles of cloth, and men marking off and cutting the goods occupied the space now used for six-bed patients' rooms. The column lay-outs were perfectly adaptable to six-bed wards.

Right: Typical main corridor on a nursing floor. In the right foreground is nurses' desk; charting desk is adjacent, with medicine room just beyond that. About halfway down the corridor is typical fire wall protected by an automatic, fire-resistant door.

5TH and 6TH FLOORS



How to Read Blueprints

A short course, in three parts, to help hospital administrators to speak the architect's language

J. M. BARROW, C. P. ATKINS and J. P. GRAHAM

SUCCESS in the planning of a hospital depends largely on the interchange of ideas between the architect and those who will work in and operate the building.

Of course, the spoken and written word enables planners to communicate to an extent on common ground. However, a better understanding of the architect's work in the advanced drawing stages—which others usually see as "blueprints"—will strengthen this bridge of communication necessary to cooperative planning.

To many, the lines, symbols and jargon found in blueprints are barely understandable. To others, they are a complete mystery!

It is our hope that the following discussions, drawings and explanations will help dispel this confusion.

First, let's define a blueprint. It is *not* a miracle document which the architect conjures up with the help of secret potions and devilish incantations. It is nothing more than a copy of a pencil or pen drawing reproduced on a special type of photographic paper. Dark lines made on the original drawing show up white on the blueprint, while the white background of the drawing paper comes out a deep shade of blue.

The lines, notes and symbols which the architect uses in his drawings comprise a sort of language—in shorthand—by which he communicates with those who perform the work. It would take expansive written volumes to furnish the builder the same instructions as are contained graphically in a comparatively few sheets of architectural drawings. This shorthand language is, truly, an indispensable tool and time saving device for those who design, engineer and build buildings. Although sometimes genuinely complicated, it is a language that can be learned through direction and practice.

The final architectural drawings from which a building is built are called "working drawings." These are prepared in great detail to show exactly how a building is to be put together to fulfill the wishes and needs of the owner. Copies of these working drawings, bound into sets, are what we call the "blueprints" of a job. These are the drawings with which we shall concern ourselves in this discussion.

Since a set of blueprinted drawings is one of the contract documents between the "owner" and the contractors who build the new building, an understanding of what blueprints say and mean is important to hospital administrators and board members in the performance of their duties.

The blueprints, with the specifications, form the explicit building instructions by the architect in his interpretation of your, the client's, needs and desires. *This is your building—no more, no less.* Obviously, it behooves you to know what is in the blueprints.

The following discussions, explanations and drawings are designed to offer a "short course" in the reading of blueprints. With a knowledge of the basic terms, symbols and conventions—and a little practice—you, too, can become familiar with this intriguing language.

Ideally, qualified builders can erect a building from the information furnished by the architect with no question as to dimensions, materials used, or the slightest detail in construction. To help make this possible, a certain amount of written description is necessary to supplement the blueprints. This written material is called specifications—also one of the contract documents. Specifications describe the work to be done, the methods of construction, the standards of workmanship, the manner of conducting the work, and the quality of materials and equipment to be used. With the help of the specifications and blueprints, contractors can accurately bid construction costs, thereby assuring the owner a fixed expense.

In the design of a hospital, much research and planning are necessary before the architect can prepare the final drawings from which blueprints are made. First, a comprehensive written program is prepared which states the needs and functions of the proposed hospital. This serves as a guide to the size and content of the building and influences its basic design. Next, schematic or outline drawings are made, putting the requirements of the program into graphic form. Once the basic scheme is determined, preliminary drawings are made which show in more detail how the building will look and how it will "work." During the entire process, conferences are held with administrators, hospital board members, the medical staff, and planning committees. Cooperative planning is an important key to a successful building.

Finally, working drawings are prepared; from them the final blueprints

The authors are members of the firm of Atkins, Barrow and Associates, architects and engineers, Urbana, Ill.

This is the first of a series of three articles on blueprints. The second will appear in the April issue.

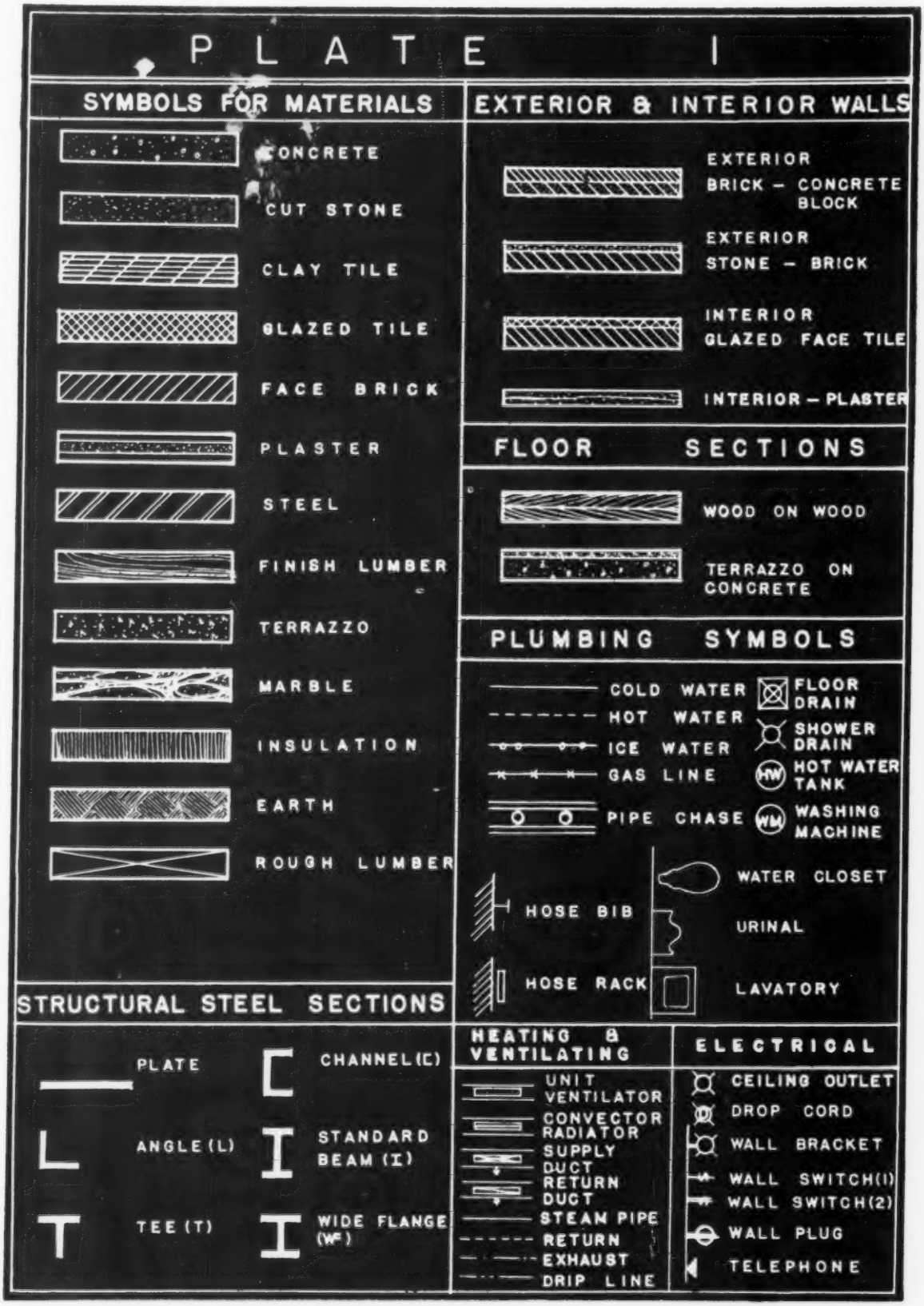


PLATE 1: Standardized symbols indicating commonly used building materials and equipment.

are made. With copies of the specifications they are given to contractors for bidding. When the various contractors have been selected on the basis of their low bids, blueprints and specifications are furnished them in quantity for their superintendents and the workmen who will perform the actual construction — carpenters, masons, steelworkers, plumbers, electricians and so forth.

In the construction of a fairly large, complicated building—say a hospital of 100 beds—a set of blueprints will contain more than 50 sheets, and from 75 to 100 sets will be needed. The sheets are fairly large, varying with the over-all size of the building and the preferences of the individual architectural office. A fairly common size is 24 by 42 inches.

Another type of drawing is also furnished the contractor—these by suppliers and manufacturers of various materials and equipment such as structural steel pieces, windows, doors, millwork, boilers, burners, pumps and so on. These are called "shop drawings" and are used by the workmen handling that particular part of construction. Although these drawings are checked thoroughly by the architect to see that they conform to his original drawings, they are not part of the blueprints as such and will not concern us in this discussion.

The information furnished the builder in a set of blueprints falls roughly into seven categories, each of which we shall examine: (1) site plan, (2) floor plans, (3) elevations and wall sections, (4) special construction details, (5) footings and foundations, (6) structural framing, and (7) plumbing, electrical and heating, ventilating and air conditioning.

The first three drawings in this series (Plate 1) are to familiarize you with some of the symbols and conventions used in the preparation of working drawings. Others are examples of drawings found in a working set of blueprints.

After studying our sample drawings —which have been kept uncomplicated —take out the blueprints of one of your present buildings, or one under construction, and go through the building with the blueprints as a guide.

The ability to visualize the finished product from a blueprint description will help you when you're planning new buildings, or remodeling old ones, with your architect. You will know what he is designing for you, and you will be able to participate more effectively in the over-all planning. It will take practice to grasp the language of blueprints, but it will prove worth while. In the future, a new building should hold no dismaying surprises of which you might say, "How did I know they were going to do it this way?"

It should be mentioned that the accompanying drawings were designed for the purpose of instruction, and, as a result, may necessarily vary from actual blueprint drawings. In some instances, to add clarity, more information is included than would be the normal practice. In other cases, largely because of space limitations, some of the drawings have been simplified or adjusted for our uses here. Generally, the reader can assume he will find fairly typical examples of what blueprints say about a small general hospital.

Plate 2

The three types of drawings found in a set of blueprints are shown on Plate 2. These are "plans," "elevations" and "sections." Plans are views from directly above; elevations are head-on views of vertical surfaces, and sections are "sliced open" views which show the actual composition of the part of the building in question. Floor plans are the most commonly known type of plan drawing, but as these also represent "sliced open" areas they are sometimes called "plan sections."

The second row of drawings on Plate 2 are floor plans, viewed from above. The right hand drawing in the top row is of a wall section. (The "load bearing wall" drawing in row three is another view of this section.) An example of an elevation is the "window units Ⓐ" drawing in the fourth row of Plate 2.

Note that dimensions for masonry walls—top of Plate 2—do not include separately applied finish materials. As shown in the first example, the 2 inch finishing glazed tile veneer is dimensioned separately. Likewise, dimensions of the interior walls of brick and concrete do not include the wall-finishing plaster. Instructions as to plaster application and its thickness throughout a building are given in large-scale detail drawings and in the written specifications.

Doors and windows are dimensioned to the openings in the masonry wall into which are placed the jambs and trim. The small encircled keys at the doors and windows—③ and Ⓐ—refer to door and window schedule drawings shown elsewhere in the set where detailed dimensions and construction information are given.

Next are isometric drawings of wall sections to show how two types of exterior walls commonly used in hospitals are made up. The first is a "cavity" wall with an air space between the brick veneer and the interior brick and tile. The two are tied together by metal "wall ties" fitted into the masonry joints. The back side of the exterior brick is given a mortar coat called "parging," not shown here, which serves as a moisture barrier. This wall is used when loads are carried by structural steel members.

The "load bearing" wall shown is a solid mass of brick and lightweight aggregate block, bonded together with mortar. Note the "header bonding" course of bricks which are placed head on into the wall. This bonding adds to structural rigidity. "Stretcher" courses are those running lengthwise along the exterior plane of the wall. A run of bricks or other masonry units standing on end is called a "soldier" course.

Following are some remodeling indications of new and old work together. Also shown are examples of window units with "hoppers" at the bottom. The dotted lines converge at the side where the window is hinged. Windows of this type which are hinged at the bottom swing in, while those hinged at the top swing out. At the bottom of Plate 2 is a part of a room schedule, found in every set of blueprints, which gives finish materials used in all rooms.

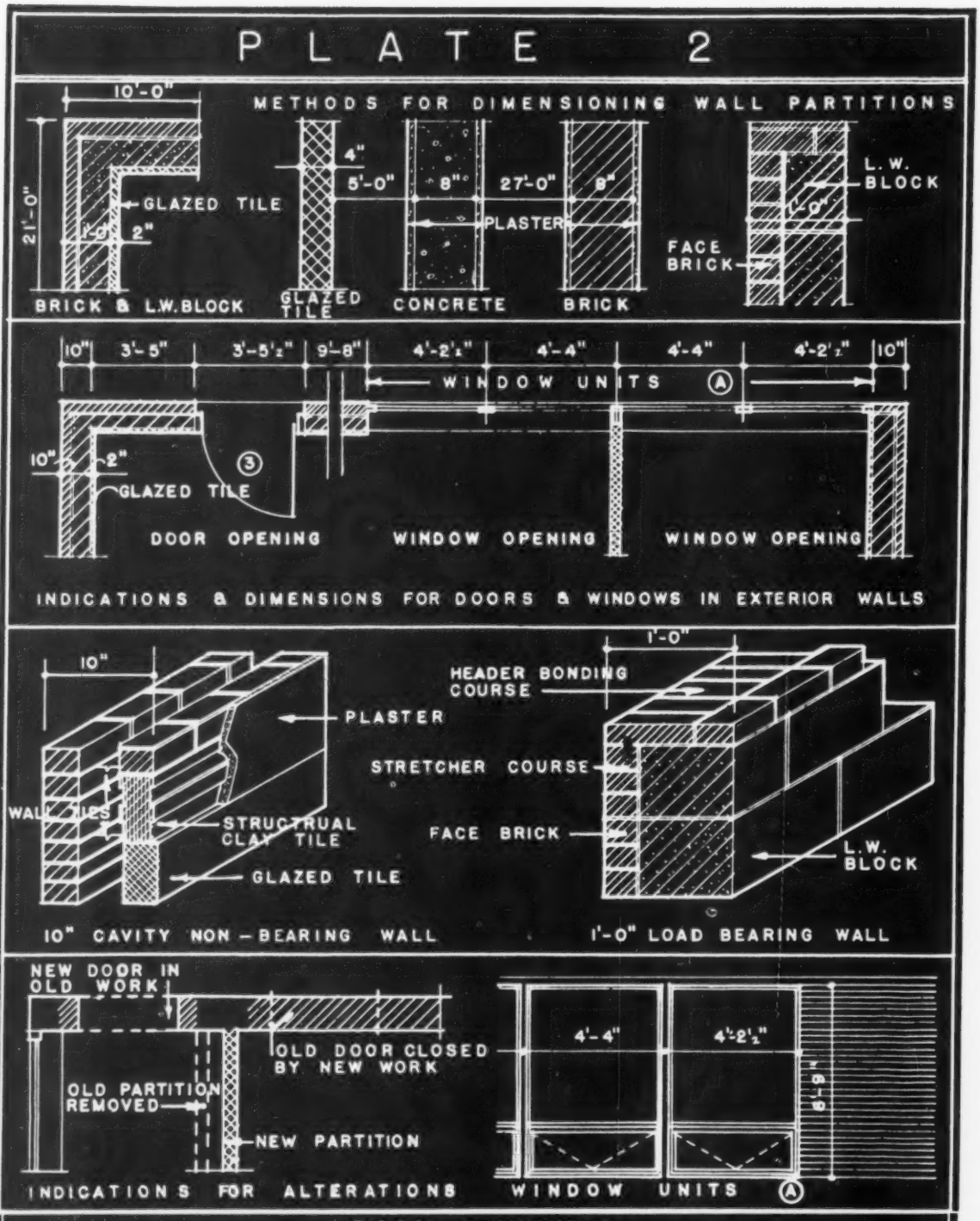
Plate 3

This is a sample working drawing of a toilet and shower area between two hospital bedrooms as would be shown in a floor plan. Numbers such as this [5] are our reference numbers and not a part of the drawing. A careful study of this drawing and an analysis of the questions and answers will help you in understanding the other drawings in this discussion and the reasons behind them.

Some of the symbols and conditions we have shown are not always found, as such, in actual drawings, but we have included them in this instructional sample to serve as background information. From here on, the drawings will be truly reflective of typical blueprint working drawings.

(See Plate 3 on Pages 72 and 73)

PLATE 2



ROOM SCHEDULE

ROOM	NO.	FLOOR	CEILING	BASE	WALLS				REMARKS
					NORTH	SOUTH	EAST	WEST	
					MATERIAL	MATERIAL	MATERIAL	MATERIAL	
TWO BED ROOM	202	ASPHALT TILE	PLASTER	ASPHALT TILE	PLASTER	PLASTER	PLASTER	PLASTER	
TOILET	203	CERAMIC TILE	PLASTER	CERAMIC TILE	CERAMIC TILE	CERAMIC TILE	CERAMIC TILE	CERAMIC TILE	CERAMIC TILE SHOWER

PLATE 2: Some of the "conventions" used in drawings to indicate and to dimension general construction conditions. A careful study of Plate 3 on the two pages following may help the reader to a better understanding.

PLATE 3

This is a sample working drawing of a toilet and shower area between two rooms in a hospital as depicted in a floor plan, showing basic lines and symbols. Numbers such as this [5] are our reference numbers and are not part of the drawing.

[1] Trim and border lines used to square and confine drawing.

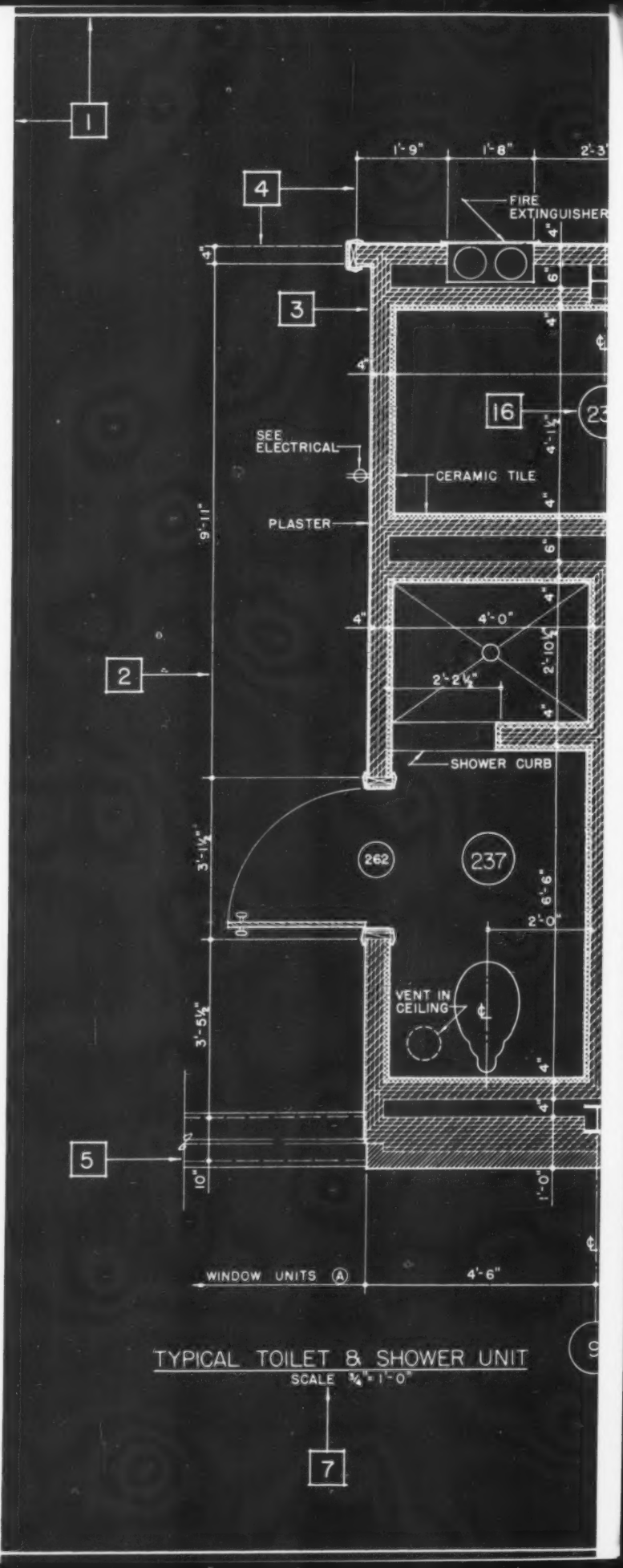
[2] Dimension lines showing distances between two points |•—2′-4″—•| or arrows |←3′-0″→|. Always use dimension figures as drawing may not be exactly to scale.

[3] Main object lines indicating outlines of walls and structural objects to which dimensions are taken.

[4] Extension lines—lines extending beyond main object lines for the purpose of easy dimensioning.

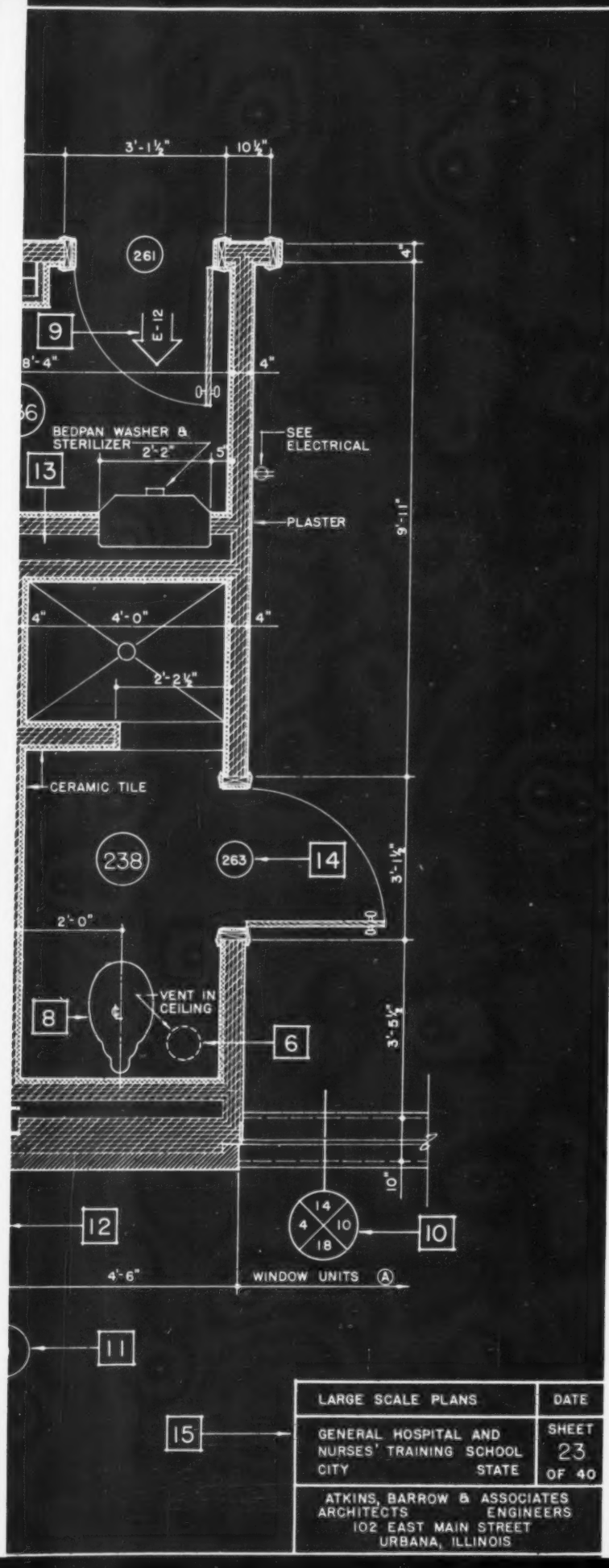
[5] Broken line indicating that the part continues but is not shown on this drawing.

[6] Dashed lines indicating an object or area which cannot be seen from our point of view in a plan, elevation or section drawing. For instance, the exterior wall lines (shown dashed) are hidden from view by the window stool inside and the sill outside. Similarly, the vents in the ceiling would not be seen in plan view which is taken at approximately eye level. They are indicated to show their relationship to other parts of the building.



QUESTIONS

1. What is the scale?
2. What are the interior dimensions of the bedpan washing room? The toilet room? The shower?
3. What materials are used in wall construction?
4. What materials are used as wall finishes?
5. What wall thicknesses do you find?
6. How many doors are shown? What are their dimensions?
7. Where is rough lumber used?
8. Why are vents in toilet rooms shown with dashed lines?
9. On what sheet will you find the section drawing?
10. How many pipe chases? How wide are they?



[7] Scale reference found on all drawings whether plans, elevations or sections. There may be several different scales used on the same drawing sheet.

[8] Equipment line which shows plumbing fixtures and other equipment.

[9] Elevation symbols indicating an area shown in elevation elsewhere in the blueprints.

[10] Wall section symbol. The number "14" is the number of the section; "4" is the number of this plan sheet; "18" is the sheet on which the section appears, and "10" is the sheet on which an elevation of this area appears.

[11] Structural column identification numbers referred to on structural drawing sheet or sheets.

[12] Center line used on drawings to determine location of equipment, fixtures, columns and so forth. The symbol of L superimposed on C identifies the center line.

[13] Pipe chase between walls to allow room for plumbing facilities.

[14] Circled numbers at doors which refer to door schedule. Windows are identified by circled *letters* and refer to window schedule.

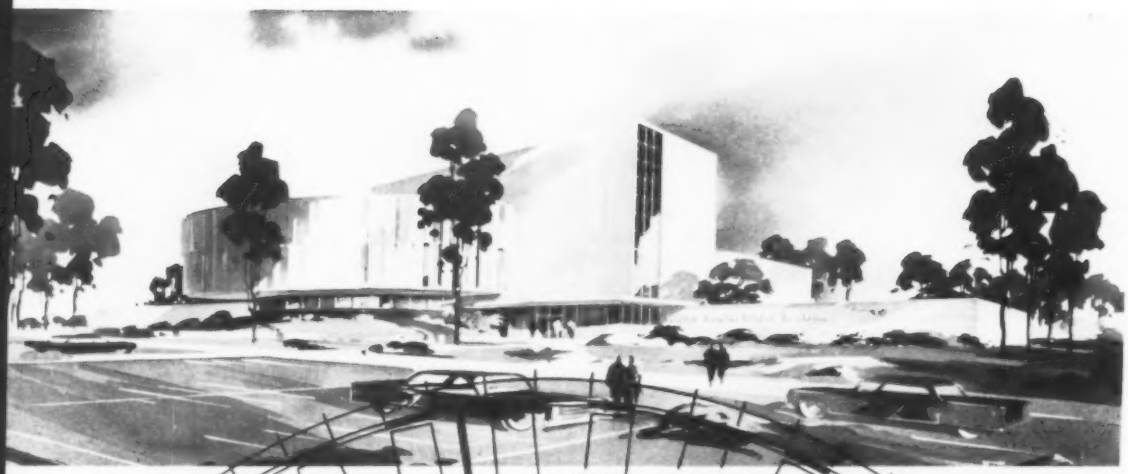
[15] Title block which appears in this location on every page but the first of a set of blueprints.

[16] Room number which refers to master room schedule as shown on Plate 2.

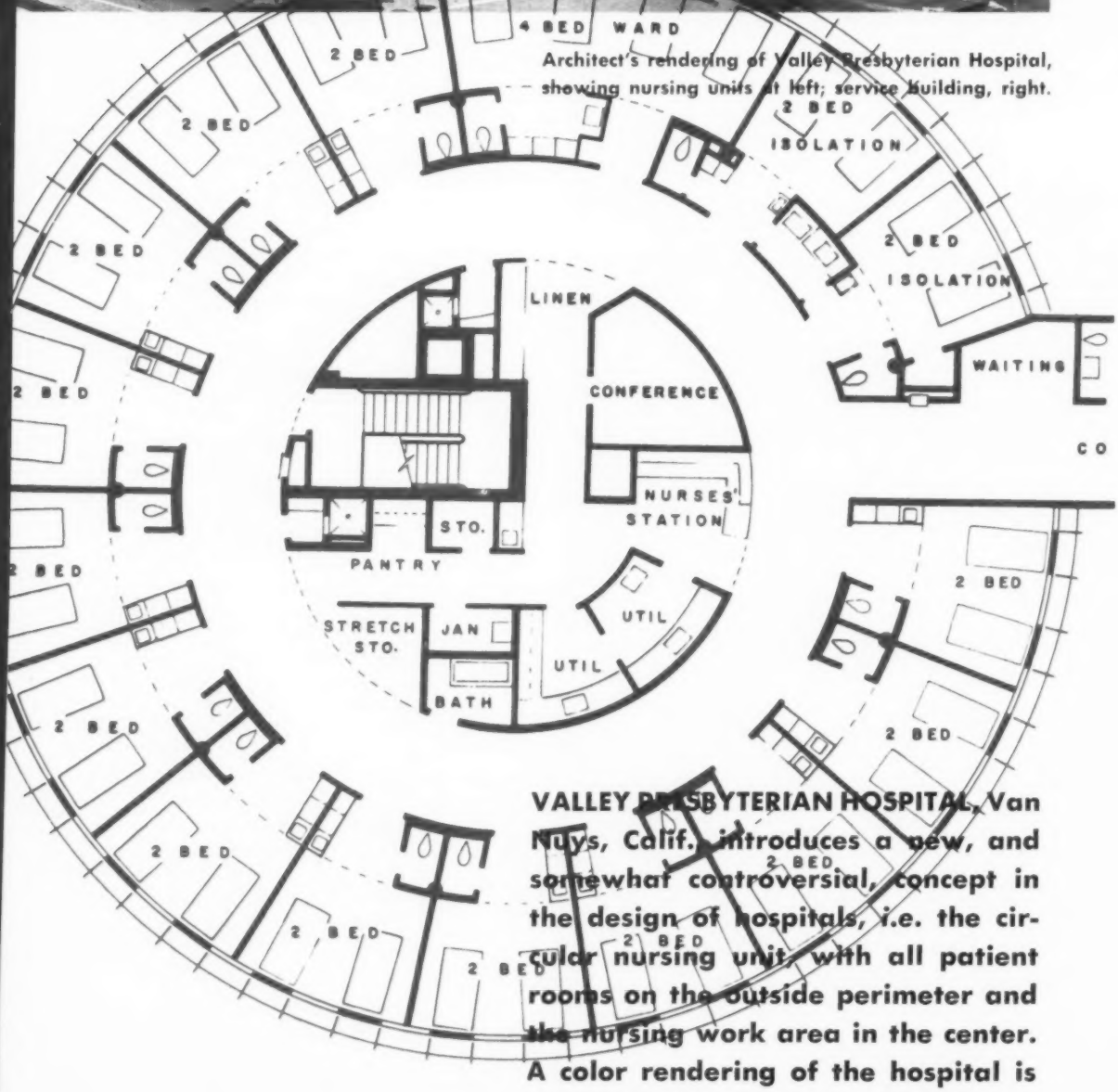
ANSWERS

1. $\frac{3}{4}'' = 1'\text{-}0''$.
2. $8'\text{-}4'' \times 4'\text{-}1\frac{1}{2}''$; $4'\text{-}0'' \times 6'\text{-}6''$; $4'\text{-}0'' \times 2'\text{-}10\frac{1}{2}''$.
3. Clay tile and brick.
4. Ceramic tile and plaster.
5. $1'\text{-}0''$; $10''$; and $4''$.
6. Three; $3'\text{-}1\frac{1}{2}''$.
7. At doors as framing lumber. Finish trim is nailed around these pieces of rough lumber.
8. A plan view is taken at eye level, which means we would not see the ceiling vents. They are indicated here by this special line for the builders' information and are shown in detail in the heating and ventilating drawings.
9. Sheet 18.
10. Two. 4" and 6".

The second article in this series on "How to Read Blueprints" will appear in the April issue.



Architect's rendering of Valley Presbyterian Hospital, showing nursing units at left; service building, right.



VALLEY PRESBYTERIAN HOSPITAL, Van Nuys, Calif., introduces a new, and somewhat controversial, concept in the design of hospitals, i.e. the circular nursing unit, with all patient rooms on the outside perimeter and the nursing work area in the center. A color rendering of the hospital is shown on the cover of this issue.

THE MODERN HOSPITAL OF THE MONTH

Architects for this new hospital say the design will save 37 per cent of nursing "mileage." Ease of expansion is also said to be an advantage of the plan, which is

Something New in Hospital Circles

SOMETHING new in hospital circles is the nursing unit designed by Pereira & Luckman, Los Angeles architects, for Valley Presbyterian Hospital at Van Nuys, Calif. The first section of the hospital, scheduled for completion this year, contains 64 beds and the necessary ancillary services; ultimately the capacity will be 300 beds.

The new circular nursing unit, the architects state, will save 37 per cent of the steps nurses have to make in a conventional hospital of similar size. All patient rooms are on the outside perimeter and nursing work areas will be in the core. Auxiliary services, such as operating rooms, x-ray, laboratory, pharmacy and central supply, are on the first floor of an adjoining rectangular building.

The circular plan is said to permit the addition of future units without any loss or remodeling of the initial plan. Every section of the hospital is so designed that it can be greatly expanded without disrupting the original unit or wasting initial equipment. For example, the kitchen can be expanded to five times its initial capacity without destroying the original layout and equipment, the architects explain.

"It is impractical in the case of a 200 bed expansion to a 60 bed facility," the architects said, "to attempt to provide any adjunct facilities capable of handling final expansion size.

"The architects have attempted in this case to solve this problem so that all future expansion adds on to the existing adjunct facilities and that none of the existing facilities have to be abandoned or ripped out during future expansion. For instance, in case of the kitchen, the kitchen will expand to accommodate 250 beds without moving any of the existing equipment. It will only be necessary to add to the existing equipment and provide additional cart storage and so forth."

This contention is disputed by a hospital planning consultant who believes that, on the contrary, "future expansion is precluded" by the circular design and that it is more costly to construct than rectangular units (see consultant's comments and architect's answers on the following pages).

Patient rooms are arranged so that both beds in two-bed rooms are next to the window. When either bed has cubicle curtains drawn and is shaded from outside light, the other bed may still have outside light and be open to the inner corridor.

Other features will include floor-to-ceiling windows, individual control of plastic sun control louvers for each patient, unit air conditioning, patios formed by walls and buildings which create separate gardens, expansible parking area, and a service area lowered below natural grade.

The second unit of the hospital to be constructed will be either a convalescent or another surgical unit, depending on which funds are available first, the architects report. Another building will be the pediatrics unit where children will be completely separated from other patients.

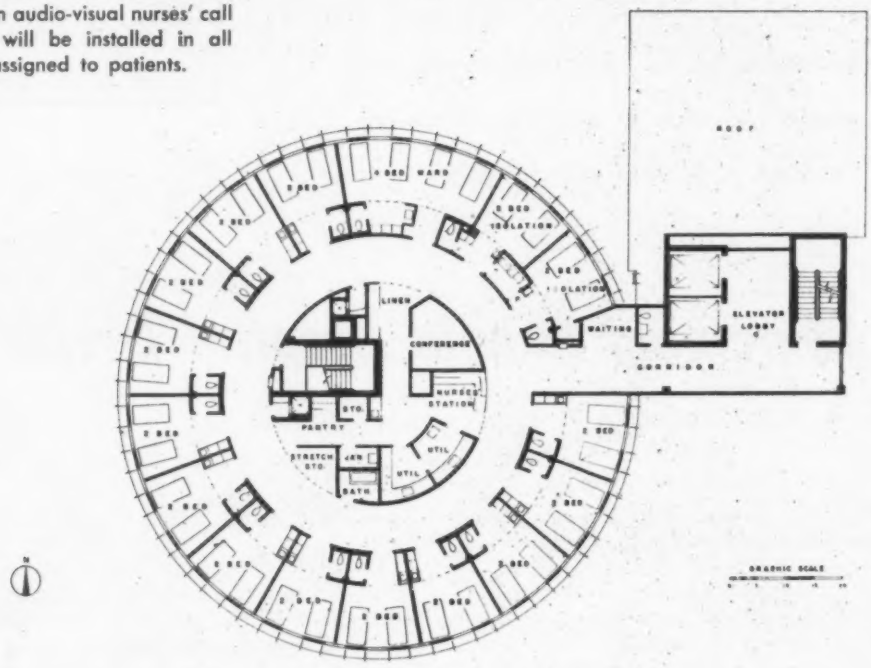
The final unit will be another medical, surgical or obstetrical one, depending on future needs. Also included in the drawings are dormitory facilities for a school of nursing, which would be the first in the entire San Fernando Valley, officials stated.

There will also be buildings for research, a teaching institution for training interns and residents, a cancer therapy section, and a heart station. (*Continued on Next Page*)

OUTLINE OF CONSTRUCTION COSTS

Total project cost, including Groups 1 and 2 equipment		**$1,523,690.00**
No. of beds	**66 (planned for 200 additional)**	
Cost per bed		**23,086.00**
Total square feet	**35,627**	
Square feet per bed	**565.5**	
Cost per square foot		**30.80**

The third floor shows a typical patients' unit, with rooms on the outside and work areas at the core. An audio-visual nurses' call system will be installed in all areas assigned to patients.



THIRD FLOOR

Cuts visibility, wastes space, says consultant

Consultant's comments are shown in bold face type; architects' replies are in light face.

CIRCULAR NURSING UNIT

Limited observation from the nursing station or from any point in the corridor.

This is certainly a disadvantage of the circular scheme, as only six to seven rooms can be seen from one position in the corridor. With our voice nurses' call systems today, this disadvantage was lessened. Stair No. 2 would only be used as an emergency exit stair and any visitor traffic would have to pass by nurses' station.

Original concept was to have many more glass walls in station area, but owners did not feel that visibility was that important.

In comparison to a rectangular plan, a smaller percentage of the floor area is devoted to patient rooms.

By comparison with rectangular plan you will find that considerably less total area is devoted to the 34 bed nursing unit in the circular plan. Some of this area does come from patient areas and would, of course, affect the percentage figure. Our clients, such as Valley Presbyterian, have only limited money to build and are greatly concerned with trying to get as many service facilities and areas as they can afford. This reduction in areas, at the cost of from $25 to $30 per square foot, enabled the hospital to build other facilities it could not have financed otherwise.

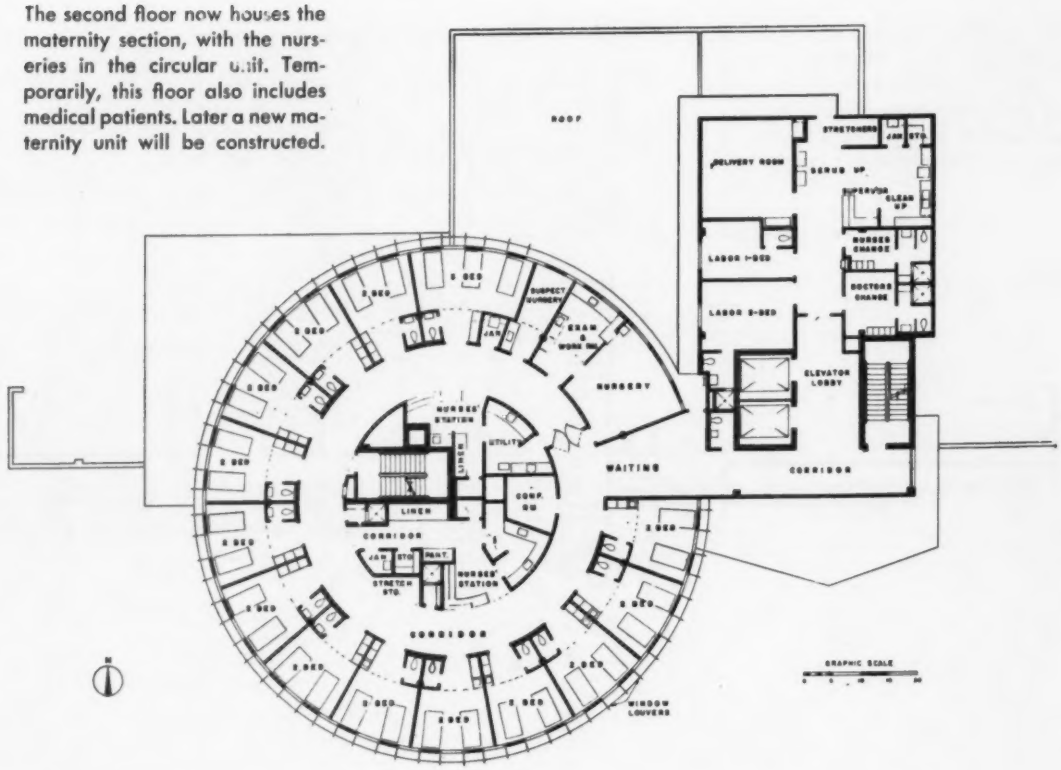
The most favorable orientation is limited to a few rooms.

In Southern California and in the area where the hospital is located, there was not any favorable orientation. All patient rooms will have sunshine during a portion of every day the year round. Actually, every room is the favored "corner room."

Future expansion is precluded. In this case, additional nursing units cannot be added vertically because of the air conditioning equipment penthouse.

Vertical expansion is not planned and from the working drawings, which were reviewed, it would not be easy to see expansion plans. Expansion up to six floors of nursing units is planned in a tower adjoining central elevator and stair core, exactly as present circular unit is connected. The elevators are so specified to go to six floors, plus basement.

The second floor now houses the maternity section, with the nurseries in the circular unit. Temporarily, this floor also includes medical patients. Later a new maternity unit will be constructed.



SECOND FLOOR

Gives space where space is needed, architects reply

The additional nursing units, which will be built on the other side of the stair core, will not have to duplicate this vertical circulation core and will use even less square footage than units being built now. The ground floor and basement would also be expanded to include adjunct facilities and services. Surgery expands to five major rooms to the northwest.

More costly to construct than rectangular units.

Cost per square foot for this unit is not enough more than conventional construction to offset the reduction in number of square feet. We do not believe we have saved any money by this construction, per square foot, but our contract price proved we did not pay a premium. Savings were effected by shorter air conditioning ducts, less perimeter wall area, less corridor area, concentrated plumbing, and so on. We, like your board, were very anxious about this cost problem, but our actual construction costs have been most encouraging.

NURSES' STATION

The nurses' station and other associated facilities inside the corridor are crowded, cut up, and give the appearance of a shoe-horn fit.

Only 59 per cent of the total floor area is devoted to patient rooms. This is much lower than in conventional plans.

In bedrooms the beds are placed perpendicular to the exterior wall, a system long since discontinued. Since the patient's head is near the exterior wall, the only possible view is interior walls and the corridor when the door is opened. The only space for the patient's chair is at the foot of the bed, not very good for reading or just sitting.

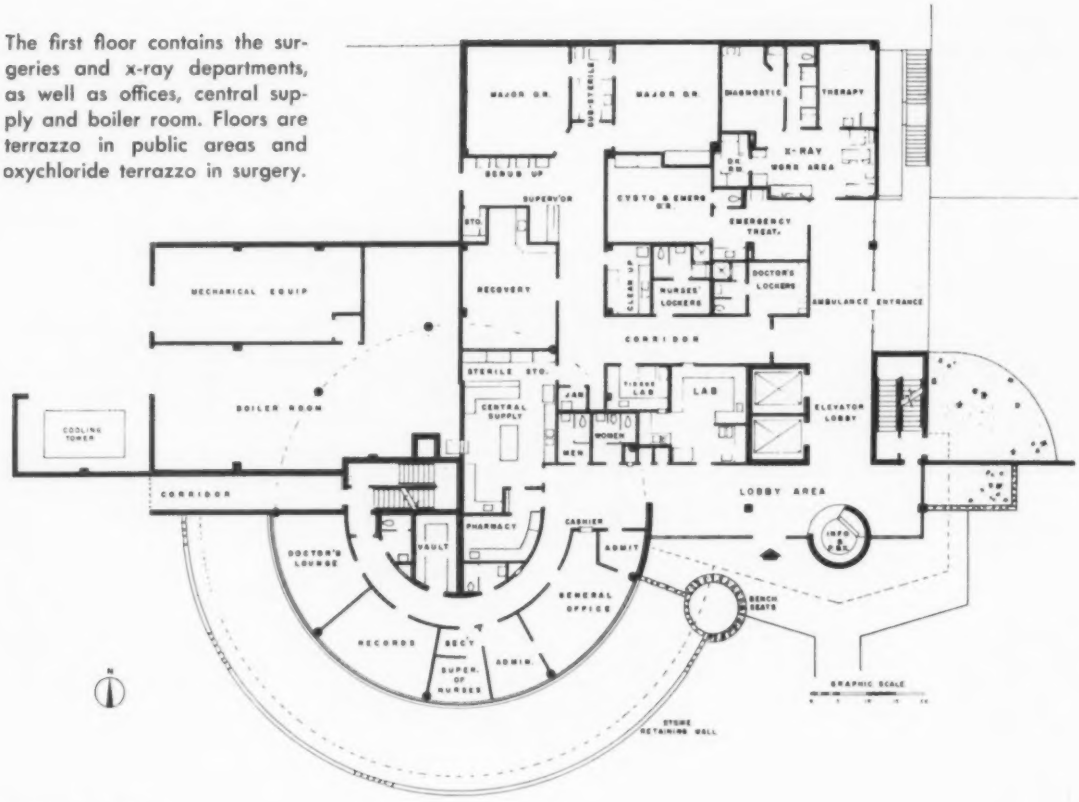
Owner's nursing staff has worked with the architects in doing layout of this area and nurses feel that area is satisfactory and full-scale mock-ups have been studied in some cases. They believe that a more compact unit saves them steps.

In the case of the nursing unit on the second floor, which temporarily serves both as maternity and medical nursing, we certainly would recommend more area. This is merely a temporary arrangement, however, as when new nursing units are added a new maternity unit will be built, and this area will be medical only.

In regard to percentage of area devoted to patient rooms, we refer to Item 2 under "Circular Nursing Unit."

The position of the bed in the room is one that received much attention here, both by architect and owner. We, like your board, did not believe that placement of beds was a good arrangement. The hospital contended that patients did not want to look out the window, but were primarily interested

The first floor contains the surgeries and x-ray departments, as well as offices, central supply and boiler room. Floors are terrazzo in public areas and oxychloride terrazzo in surgery.



FIRST FLOOR

in what went on in the corridors. We then interviewed patients in several hospitals and were surprised to find venetian blinds that were never in view position and screens in front of windows. The patients were not concerned with the outside view, and those who thought they were admitted to being even more concerned with corridor activity.

With present antibiotic procedures and with the reduction in length of stay in the hospital, very little attention is given to exterior view. In the present layout a patient needs only roll over on his side to look out a window on either side of bed. Light for reading in bed is superior because it comes from patient's back.

In actual full-scale mock-up of this patient's room, there is room for a patient's chair alongside bed next to wall for patient to sit on.

X-RAY

Both the diagnostic room and darkroom are crowded and I would want a light lock or maze at the darkroom entrance. In the space marked "work area," it would seem unreasonable to have this one area serve the following functions: film developing, x-ray reading, film filing, consultation, office work, waiting and control space for deep therapy machine.

We agree that the x-ray department is crowded. Actually, very few 64 bed hospitals are even able to have both diagnostic and therapy facilities available. It is a temporary location in this project, as a more complete facility, including cobalt and isotope laboratories, is planned for the second phase of expansion. Again, we agree that this area is small, but we want to point out that this is only a 64 bed hospital and that the number of technicians to be employed will not be the same as for a 200 bed facility. There would probably be only two people running the entire department.

EMERGENCY

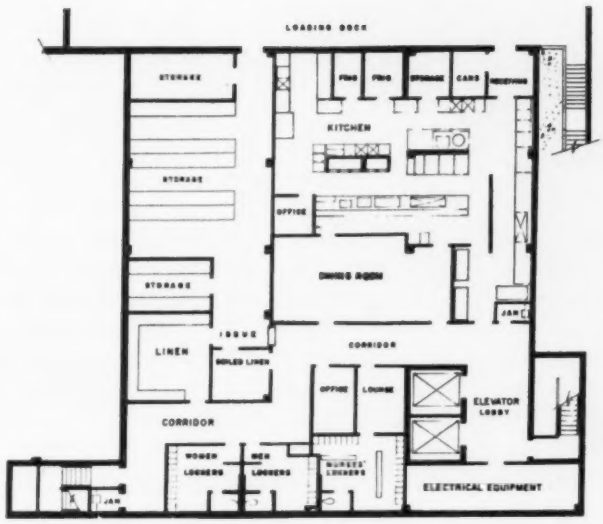
Placing the emergency entrance and waiting near the elevators used for passengers and in view of the main lobby would be considered highly objectionable. A toilet should be accessible to the waiting emergency patients. Combining the functions of cystoscopy and emergency operating in the same room compromises good medical practice.

Again we agree, but it must also be realized that we have to make a compromise when we build a 64 bed hospital that is to expand (with a minimum of inconvenience and cost) to a 250 bed medical facility. The emergency room location is only temporary. There was some discussion about the view into emergency from the lobby and this was weighed against the loss of control of all entrances from the central PBX-information area. It was decided that during the first phase a screen would be set up in the corridor between Elevators 1 and 2, which would be removed at night for better control.

BASEMENT

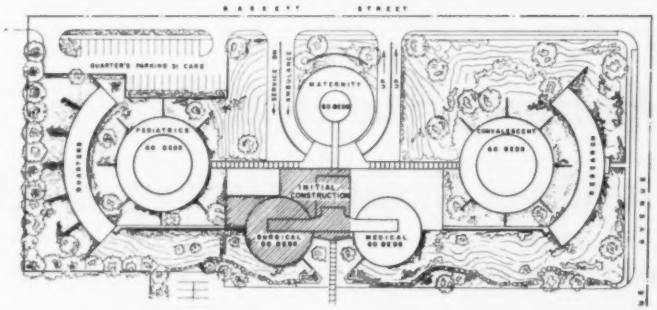
Food preparation and dining areas are in the basement of the rectangular unit, as are storage rooms and lockers for personnel. A sprinkler system has been installed in the basement. A water softening system has been installed for all domestic water.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and state officials. A similar award will be made each month.



FINAL DEVELOPMENT

Plot plan showing how the hospital will look when it is finally completed. The shaded areas show the sections concurrently under construction. The present 64 bed capacity will be expanded to 250 beds.



TRAFFIC

The only access to the receiving end of central sterilizing and supply is through the main lobby. This means soiled articles from floors above and supplies delivered to the hospital at the floor below arrive by elevator, thence through the lobby to central sterilizing and supply. The same goes for the pharmacy. Pickup of soiled linen and delivery of clean linen is made through general storage area.

The original plan called for a dumb-waiter to serve both pharmacy and central sterilizing areas. During plan review, this was taken out because owner felt that he would rather service these units daily by cart. All soiled articles would come into C.M.S. through surgery entrance.

Second phase of construction would relocate the pharmacy and expand central supply into pharmacy area and also into laboratory area.

Linen pickup and delivery was not considered too serious a problem for a 64 bed facility. We must keep in mind that this is not a large hospital and that cost was a critical factor.

DELIVERY

The mixing of clean and dirty function in the same work area is not good practice. We prefer the cleanup area to be separately enclosed.

This delivery layout is colored by the operating problems for such a small maternity unit. Both local and state health departments concurred that this layout would be acceptable practice for a small unit. Staffing such a small unit is a great penalty for any small hospital and we and the health authorities have agreed to give the hospital every break possible.

KITCHEN

It is highly desirable to locate the dishwashing machine so that the operator handling soiled dishes cannot handle clean dishes. This is usually accomplished by providing a dishwashing room with the clean end of the machine projecting into the kitchen. It further has the advantage of isolating noise and moisture and also provides a place to wash the food trucks. Food handling codes require a separate hand-washing sink. A three-compartment sink for soak, wash and rinse operations is highly desirable and mandatory in some states.

Here again we want to point out that this dietary facility is for a 64 bed hospital. It is so designed that Phase 2 will accommodate a kitchen for 250 beds and none of the heavy cooking equipment will have to be moved. Some units will be added, but none moved. A new dishwashing room, service elevator, and card service room will be added at that time, as well as more refrigeration space.

Exterior of Providence Hospital, Washington, D.C. The building has a capacity of 350 beds and cost $6,061,669. It was opened to patients last April.

"Modern Hospital of the Year" for '56: Providence Hospital, Washington, D.C.

PROVIDENCE HOSPITAL, Washington, D.C., has been selected as "Modern Hospital of the Year" for 1956. The selection was made by a committee of architectural and hospital authorities, following study of all the projects presented in the "Modern Hospital of the Month" series during the year.

The Providence Hospital was designed by Faulkner, Kingsbury & Stenhouse, Washington architects. The hospital was opened for patients last April. It has 350 beds and was built at a total cost of $6,061,669.

Outstanding features of the hospital, according to Sister Eleanor, administrator, are its location permitting a panoramic view of Washington from all patients' rooms, as well as from the solariums provided on every floor; a cross-shaped plan permitting location of the clinical services in separate wings, accessible to personnel but reducing noise and congestion in patient areas: complete air conditioning; the large postoperative recovery room, and harmonious blending of colors throughout the building to achieve an atmosphere of warmth and comfort.

The hospital is the result of joint planning by administration, personnel and architects, the administrator reported, and staff members and department heads have been pleased with the way the plan is working out in actual practice. Some of their comments follow:

Dr. Louis J. Goffredi, department of surgery: "The department of surgery is in close proximity to the departments of radiology, pathology and cardiology. This well planned arrangement is a distinct advantage to all these other departments, especially where emergency services are needed. Each of the major operating rooms is completely equipped for general surgery and additional specialty equipment is immediately available in the centrally located supply room within the department. This suite is entirely air conditioned which, in a climate such as we have in the District of Columbia area, presents real comfort and advantage to both patient and staff. Elevator service exclusively for this department was not planned but would be desirable. It is the unanimous feeling of the staff that all efforts have been made to attain a maximum in safety and comfort to the surgical patient."

Dr. Jean E. Paquin, obstetrical department: "The privacy and convenience of private labor rooms are appreciated by the mothers. Facilities in the labor and delivery section have been so arranged that the nurses' station is centrally located, saving steps and assisting the nurse to give better patient care. I have not heard a patient-complaint since the hospital opened, although I have frequently asked my patients for their recommendations and suggestions."

Sister Teresa, chief dietitian: "The dietary department is a dietitian's delight. Convenience in arrangement of facilities and attractiveness in colors, lighting and general appearance are important factors in enabling us to render prompt and efficient patient service."

Dr. Kenneth L. McCoy, director of laboratories: "The hospital laboratories occupy a location convenient to both clinic and house patients. The laboratory is equipped to undertake a wide range of procedures. Research areas have been included and are fully utilized. Additional space for hematology and bacteriology would be desirable in our hospital, as these are ever-expanding services."

Dr. John A. Long, director, radiology department: "We are especially pleased with the wall tile in the corridors and with the general color scheme, which is most attractive. It would be helpful if the cystoscopic rooms were closer to x-ray and it is felt that the deep therapy room is rather small. However, these are minor items in comparison with the many excellent features."

(*Continued on Page* 146)

Liability for Acts of Interns and Residents

Whether the hospital is held responsible for the acts of its interns and residents depends upon whether they were acting as servants of the hospital—a question courts must decide on the finding of fact in each case

ALBERT WOODRUFF GRAY

FROM an English statute of a little less than seven hundred years ago has come the law—*respondeat superior*, or let the master answer—that usually governs the liability or absence of liability of a hospital for the negligence of residents, interns and nurses. The master must answer for the acts of the servant and the consequences of the negligence of employes, so long as they are acting as the servant of the employer.

Before the supreme court of Iowa there came for review only a few months ago a judgment against the Des Moines Still College of Osteopathy and Surgery. A patient had been awarded damages for burns incurred during her anesthetization. The hospital contended in its defense that the mere burns did not show they had been derived from negligence of employes for whose acts the hospital was answerable. The state supreme court said:

"Clearly then, except when employes regardless of class were 'loaned' or were engaged in the practice of osteopathy, this hospital determined and directed their duties and made assignments. With these exceptions it had complete control over the doctors and nurses employed by it. He who has control over servants must respond in damages for their acts."

To this the court added, "Conceivably the hospital could escape liability by a satisfactory showing that it did not control its servants (1) because they were loaned to another, or (2) they were acting as independent practitioners of osteopathy. Although it is true that the professional discretion of hospital and staff doctors cannot be controlled by the unlicensed corporation, nevertheless this rule, even when those individuals are performing nonprofessional functions under the master-servant relationship, will not protect the corporation from liability for its servants' negligence."

Further, whether or not this master and servant or employer and employe relationship exists, thereby imposing liability on the hospital for the negligence of employes, it is not a question of law but one of fact for the determination of the jury under the circumstances of that particular instance.

In contrast to this Iowa case is a decision by a New York State court of a lawsuit involving the administration of an antiseptic where the acts were those not of hospital servants but of the assistants to the surgeon in charge. The distinction appears clearly in the comment of the court sustaining a decision in favor of the hospital.

"The applications of the antiseptic to the victim's body immediately preceding the surgery were part of the operation itself and, therefore, were acts in the nature of treatment of the patient for which the hospital was not liable. It was the duty of the operating surgeon to see that there were no inflammable gases present in the area in which the electric cautery was to be used by him and the direct responsibility for what was done was part of his obligation as head of the 'operating team.' If he was remiss in that respect his conduct was in any event a medical omission for which the hospital would not be liable."

On the other hand the immunity accorded hospitals by the courts from the negligence of surgeons and their assistants when acting in a professional capacity, on the ground that they are independent contractors for whose acts the hospital cannot answer, does not extend to negligence and carelessness on the part of the hospital in their selection of such personnel.

Judgment against the owners of the Mercer Sanitarium at Mercer, Pa., for the death of a mental patient, was rendered by a federal court a few months ago. The victim had been permitted to walk about unattended, fell down a flight of steps and was killed.

In that decision the federal court said of the circumstances distinguishing incidents in which a hospital is liable for the negligent conduct of its servants or employes and those to which this rule that the master must answer does not extend:

"It seems that the negligent performance of routine matters renders a private employer liable because he retains the right to direct not only the manner in which the work is to be done but also the specific result to be accomplished.

"Utterly dissimilar is the negligence occurring in the course of treatment, where medical and professional services by doctors and nurses are required and the employer has no control, actual or potential, over either the result to be accomplished or how it is to be accomplished. In such circumstances physicians and trained nurses exercise their undirected judgment and discretion and act as independent contractors.

"It is fundamental that a principal cannot be held liable unless he is the master of the negligent party and as such controls or has the right to control the conduct of his servant. Control or potential control over the servant

Mr. Gray is an attorney, New York City.

seems to be the essence of liability."

In West Virginia an employe of a coal mining company had fractured his arm which was temporarily put in splints by a local physician. The patient was then sent by his employer to the Charleston General Hospital. After the arm had been x-rayed by a hospital specialist the patient was told to go home and that he would be advised of the results. Three days later he received a letter: "X-ray of arm shows fracture of both the ulna and radius in upper third with very little displacement. New splints will not have to be applied."

When the splints were removed his arm was crooked. Two operations were performed in an unsuccessful attempt to correct the effects of the negligence of the hospital's x-ray specialist in the original examination. Of the responsibility of the hospital for the negligence of the x-ray specialist and its defense that this specialist was an independent contractor the court said in its decision:

"For two very good reasons the defense of injury by an independent contractor cannot be maintained. The radiologist was employed and paid by the hospital to perform work in discharge of its own contract and undertaking to diagnose and treat the injury. Farming out work to be done under a contract never relieves from the obligation of the contract. A man cannot avoid his contract by devolving performance thereof upon a stranger."

Even more clearly does this distinction appear in a recent New York case between circumstances invoking that Thirteenth Century rule of law that the master must answer for the sins of his servant and the freedom ordinarily enjoyed by the master when the employe acts in the rôle of an independent contractor.

In that instance an applicant for a job with the Sunshine Biscuit Company was required to submit to a physical examination to ascertain whether she was physically fit for employment. She was examined by a physician regularly employed by the company. Attempting to obtain blood from her arm for a test he probed repeatedly beneath the skin. Shortly afterwards the woman's arm developed a paralysis, "causalgia." In its decision the court said:

"This company relies on the rule, formerly established in this state, exempting hospitals from liability for negligence of their physicians and nurses in the treatment of patients. This rule has been applied in favor not only of charitable and private hospitals but also of private corporations which engage physicians for the treatment of employes or third persons.

"The cases which have thus far come before us have involved negligence occurring in the course of the treatment and care of a patient who was at the hospital seeking relief or a cure for some malady with which he was afflicted. In each such instance a doctor-patient relationship existed and the doctor determined what was to be done. In these cases where the wrong was committed in the course of the treatment, immunity, when granted to hospitals, was based upon the following reasoning. Such a hospital undertakes not to heal or attempt to heal through the agency of others but merely to supply others who will heal or attempt to heal on their own responsibility.

"At the heart of this rationale lies the thought that the hospital does not cure the patient. Rather, it procures a physician who, in rendering the treatment, exercises his own judgment and discretion, undirected and uncontrolled by the hospital.

"Where the physician's negligence has occurred in the course of the treatment which he determined to give, we have applied the rule that if at the time of the wrong he was engaged in a 'professional' act, he was acting as an independent contractor and the hospital would not be liable. If, on the other hand, his negligence was 'administrative' then the hospital will be held responsible, for he was acting as its servant.

"Thus even where in the course of treatment the patient is injured through a negligent 'administrative' act, such as failing to erect sideboards after deciding they were necessary, or

HATS OFF TO HATTIE: NURSE'S AIDE AT ST. FRANCIS HOSPITAL, PEORIA, ILL.,

Hattie Parker

HATTIE PARKER, whose picture is shown here, has been honored by St. Francis Hospital, Peoria, Ill., where she is a nurse's aide, for rescuing a patient from a burning oxygen tent. At 4:30 one morning, Mrs. Parker heard a scream and saw a flash of light emanating from a patient's room. She knew at once what had happened—and just what she must do. Running to the room, she turned off the oxygen and smothered the fire with the bed sheet. The patient, who had lighted a forbidden cigaret, escaped with facial burns.

Writing about Mrs. Parker's exploit in the hospital bulletin, the *Grapevine*, hospital officials pointed out that her action proved, if proof were needed, that "the fire prevention program [conducted by Lt. Robert McGrath of the Chicago Fire Prevention Bureau] paid off in just this one instance, for there is no doubt that the training Hattie received during those days came to her aid in that great moment of need."

Left: Fay Conley, pediatric supervisor at Pekin Public Hospital, demonstrates hip carry removal.

Right: Mr. Weber of Pekin Public Hospital is carried downstairs by Students Rita Fultz (left) and Roberta Bohm of Peoria.

giving a blood transfusion to the wrong patient, the hospital is liable. In such cases it is not the person, *i.e.* the physician, nurse or orderly, but the nature of the negligent act which determines the hospital's liability."

Here where there was no treatment or care involved, no doctor-patient relationship, the physician did not act independently but merely obeyed an order given by his employer. The physician's act was done entirely for the purpose of furnishing to the employer in its business a report of the physical condition of the applicant. The physician was a servant, not an independent contractor, and the employer was held liable for the injury incurred through his negligence.

Recently there was before the federal court of appeals an instance of the character mentioned by the court in its decision of this New York case, where the hospital was held responsible for injuries to a child at its birth, consequent on the negligence of the assistant resident in charge of the obstetrical ward and the nurses. At the time of this birth no physician was in attendance. The assistant resident who had examined the mother less than two hours before could not be found.

In sustaining the verdict of the jury against the hospital on this charge of negligence for the failure to have available, as was its duty, the necessary medical care, this federal appellate court said: "In general it is the duty of a private hospital to give a patient such reasonable care and attention as the patient's condition requires. This duty is measured by the degree of care, skill and diligence customarily exercised by hospitals generally in the community and by the express or implied contract of the patient.

"If a hospital undertakes to render services customarily performed by physicians, it must perform such services with the same degree of care to which a private physician is held; that is to say, the physician employed by the hospital must exercise the ordinary skill and care which is generally exercised by the members of his profession in the community giving consideration to modern learning."

In a municipal hospital in Miami, Fla., occurred the same situation. There the jury found the acts of the intern were outside the immunity blanket covering the hospital when its employes are acting as independent contractors. Here the jury returned a verdict for $3500 in favor of the patient.

In his preparation of the patient for the operation this intern had left alcohol saturated gauze on the patient's body near the place to be cauterized which had ignited from an electric cautery. Here the old defense was interposed, that the hospital's sole duty was to exercise due care in the selection of its employes as it neither could nor did control the manner or method of treating patients.

From this judgment the hospital appealed and in its affirmance the supreme court of that state recited this rule whereby the liability of a hospital for the acts of physicians or interns are determined by the presence or absence of the relationship of employer and employe and the control by the hospital of the method and manner of the performance of the services.

"There can be no question but that a hospital is as much liable for the negligence of an intern who is in nowise an independent contractor but a mere employe, as it is for that of a nurse under like employment," said that court.

"Aside from all this, the negligence complained of in this case was such that it could not be said that the intern was exercising his professional skill and judgment in applying the healing art when he did the thing complained of and which caused the injury.

"It did not require any knowledge or skill of medicine or surgery for anyone of ordinary intelligence to know that if one saturates a lot of gauze or sponges with a large quantity of high grade alcohol and then brings a red hot iron into close proximity with those saturated materials they will immediately ignite and burn and when the intern so carelessly and negligently saturated such materials

DEMONSTRATES THE VALUE OF FIRE SAFETY TRAINING BY RESCUING A PATIENT

Right (l. to r.): Donna Draeger, Nancy Spainhower and Rosemary Sell, St. Francis Hospital, show how to slide heavy patient down the wall.

Left: Student team from St. Francis demonstrates six-man removal from bed to blanket for Pekin observers.

St. Francis' program is paying off in other respects, too. The accompanying pictures illustrate a training session staged by seven St. Francis student nurses at Pekin Public Hospital, Pekin, Ill. They went to Pekin at the special invitation of the administrator, George T. Weber, who had been impressed by their performance during a public demonstration last October and requested help in training his personnel.

As the Peoria students demonstrated the basic technics, the Pekin nurses gradually worked in with them and were soon able to work alone. Teams were formed and worked under the direction of the visitors. After all the carry procedures had been mastered, pupils and teachers repaired to the boiler room for a demonstration of the use of various types of fire extinguishers.

Following the session, Mr. Weber wrote to Lt. McGrath as follows:

"You may well take pride in your protégés; these youngsters are good enough to go out and teach fire safety. They showed our people how it is done; now we are doing it ourselves."

and placed them on the naked abdomen of the patient and then brought a red hot cautery into close proximity therewith, he was bound to know what the result would be just the same as one who would drop a lighted match into a gasoline tank might expect to cause an explosion."

In a similar case in New York State a few years before this decision was made by the Florida court an intern in the Crown Heights Hospital in Brooklyn injured a patient by administering a clysis injection so hot that the patient was compelled to remain in the hospital three additional weeks for treatment.

"INTERN EMPLOYED AS DOCTOR"

In its defense to the suit brought against the hospital it was contended that the intern was employed as a doctor and in administering the injection he had acted in this professional capacity, and not as an employe of the hospital.

"Liability, if any," said the court in its decision, "must be predicated upon the ground that the hospital was the master and the intern was the servant. The intern was the hospital's regular employe. What he did was within the scope of his duties for the hospital and was part of a service for which the patient was paying the hospital. The intern was not an independent contractor so far as the patient was concerned."

Of these rules of law governing the liability of hospitals, or the lack of it, for the negligence of physicians and interns, the supreme court of Virginia in its decision of an action against the Stuart Circle Hospital in that state said in a summary of this law:

"A hospital is not responsible for the acts of an attending physician whether a member of its staff or an outsider, except where by the contract it has assumed responsibility. This is based on the ground that such a physician is an independent contractor and alone is responsible for the exercise of professional skill and judgment, subject to no control by the hospital in the execution thereof.

"The intern is not an independent contractor so far as the patient is concerned. His contract is with the hospital. His service is a part of the numerous duties prescribed by the hospital and he is selected, employed, directed, supervised and paid by the hospital.

"Both the intern and the nurse are specially and highly trained. Both belong to trained and skilled professions. Where both are employes of a hospital and work directly under its supervision and control there is no substantial difference in their relationship to the hospital. In rendering such services they act on behalf of their employer."

Only a few months ago a patient at the Rutland Hospital, Rutland, Vt., was injured through the negligence of a registered nurse acting under the supervision of the attending physician. Suit against the hospital for damages ended in a decision in favor of the hospital. In sustaining this determination the appellate court said of residents, interns and other hospital employes:

"When one person puts his servant at the disposal and under the control of another for the performance of a particular service for the latter, the servant in respect of his acts in that service is to be dealt with as the servant of the latter and not of the former. We must carefully distinguish between authoritative directions and control, or mere suggestions as to details or the necessary cooperation, when the work presented is part of a larger undertaking.

"While the assisting physicians and nurses may be employed by the hospital or engaged by the patient, they normally become the temporary servants or agents of the surgeon in charge while the operation is in progress."

This the Vermont court supplemented with a reference to a Minnesota court decision in which the law governing the liability in these sometimes confusing circumstances was outlined.

"It is well established that a hospital is liable to a patient for the wrongs of its employes under the doctrine of "the master shall answer." The problem then is simply one of master and servant—whether nurses at the time of the alleged negligence were the employes of the doctor or of the hospital. Concededly they were in the general employ and pay of the hospital and assigned by it to assist in the operation.

"However the acts complained of occurred during the operation, were ordered and checked by the operating surgeon and were of such a nature that, according to his testimony, the nurses while performing them were under his absolute control.

"The true test of the existence of the relation of master and servant in a given case does not depend upon whether the servant was in the general employ of the master, but upon whether the master actually exercises supervision and control over the servant during the time he uses such servant. A general master may loan the service of his employe to another for a specified purpose and for a short period of time, in which case the individual to whom such general servants are loaned is the master and responsible for their negligent acts so long as he exercises actual supervision over them.

"Where a servant has two masters, a general and a special one, the latter, if having the power of direction or control, is the one responsible for the servant's negligence. The desirability of the rule is obvious. The patient is completely at the mercy of the surgeon and relies upon him to see that all the acts relative to the operation are performed in a careful manner. It is the surgeon's duty to guard against any and all avoidable acts that may result in injury to the patient.

"The rule is plain that when the general employer assigns his servant to duty for another and surrenders to the other the direction and control in relation to the work to be done, the servant becomes the servant of the other insofar as his services relate to the work so controlled and directed.

"The general employer is no longer liable for the servant's wrongdoing committed in the directed and controlled work. In the operating room the surgeon must be master. He cannot tolerate any other voice in the control of his assistants."

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Trial-and-Error Nurse Education Is Costly

Careful planning of inservice education for nurses is worth the effort in terms of time saved, better care of patients, and more satisfaction for nurses

KATHRYN SLAVIN, R.N.

CHANGES in nursing conditions and practices have created staffing problems that call for a definite program of orientation. Albany Hospital, Albany, N.Y., as a teaching and medical center, has new house officers and new medical and nursing students rotating through the various services. Increased mobility of the population in Albany is partly responsible for considerable turnover among nurses and auxiliary workers. Nursing needs require recruitment of relief nurses who frequently are strangers to the hospital or have been away from nursing practice for some time. Obviously, in promoting the most effective care of patients, definite planning is necessary if correlation between content and practice in all the educational activities is to be accomplished.

Perhaps by indicating some of the needs in our hospital which led to my being placed in charge of planning staff education, the specific reasons for developing such a program can be explained more fully.

There is little that remains static in our hospital situation these days, and hospital policies, nursing procedures, and administrative routines are being constantly revised or developed. As a result, difficulties in communicating and interpreting these changes have arisen. Our staffing situations brought about the need for coordinating the implementation of routines and technics wherever feasible throughout the hospital. Primary in our hospital, as in all hospitals, was the need for improving work performance in giving better care to patients.

The hospital recognized the necessity of providing for staff education along these same lines in order to operate more smoothly and to promote greater job satisfaction on the part of its staff. The need was felt, also, for improving learning situations for students, auxiliary personnel, and new staff personnel.

This exploration of needs led us to set up the following objectives in developing a planned staff education program.

General Objectives

To provide the opportunity for inclusive staff instruction.

To establish a definite plan of orientation for new and rotating staff personnel.

To ensure the opportunity for professional growth.

To ensure correlation of content and practice in all education activities throughout the hospital.

Specific Objectives

To promote improved and effective patient care.

To provide improved work situations and satisfaction for personnel.

To establish improved lines of communication and interpretation regarding policies, procedures and routines.

To promote coordinated implementation of routines and technics whenever feasible.

From the objectives, it was apparent that planning should progress in three different areas.

1. Staff inservice classes for the nursing personnel needed to be developed.

2. An orientation program for new and rotating personnel needed to be organized.

3. Opportunities for professional growth of the nursing staff needed to be provided.

Still another question calls for an answer. Who is going to have the responsibility and, more important, the time for all this planning? Again, we look to new trends and see that it has been found desirable to designate a qualified member of the staff who has sufficient time for planning and activating a dynamic program.

Whether the entire time of the individual is to be devoted to the program, or only a certain number of work hours, depends upon the particular situation. It is well to mention that time spent in planning is time saved in preventing duplicated effort while ensuring sufficient opportunity for staff education. Important also to hospitals is the fact that the trial-and-error method of learning is costly both in time and, ultimately, money, and in safety for patients.

The first approach to planning the staff education program was to get acquainted with the people who were to take part. Cooperation depended upon an understanding of the reasons for the program and the objectives to be achieved. Getting acquainted also provided an excellent opportunity for obtaining insight into the felt needs of the staff. Rather than setting up a course of instruction far in advance, we chose the subjects and contents of our inservice classes in accordance with felt needs whenever possible. Research on all the available material was also an important step in determining trends

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and policies which have been found useful.

Since many of our graduate and practical nurses have had little opportunity for planned orientation, developing and instituting the inservice classes was the first step. Policies in regard to these classes included required attendance at a one-hour class each week, classes given on duty time or time paid for when necessary, and classes given four times a week to allow for service needs and days off.

OFFERS EFFECTIVE PATIENT CARE

The classes were designed to promote more effective patient care and greater job satisfaction for personnel through a planned opportunity for obtaining information about nursing procedures, hospital policies, and administrative routines. Lectures, demonstrations and the use of audio-visual aids whenever possible are the methods of presentation by head nurses, staff nurses, instructors and administrative personnel from the various departments. Their willingness and cooperation have contributed to making the classes satisfying and worth while. Questions from the group have brought to light problems and have created opportunities for clarification and explanation.

Some examples of the kinds of classes in our inservice program may explain the method we have used in planning staff education. When our inservice classes were first instituted, the procedure committee was in the process of revising and streamlining nursing procedures. In order to familiarize the nursing personnel with changes that had been made, revised procedures were made known in the class.

The advantages to be gained by presenting revised procedures to the group were clearly shown by the class given on card indexing. In our hospital, the card index system has proved to be one of the most important and useful tools in helping to ensure safe and correct care for patients. It provides pertinent information about each patient, including the particular medications and treatments being given and diagnostic tests being made. The opportunity for a double check with medication and treatment tickets before proceeding with an assignment is invaluable.

Findings of the committee indicated the need for modernizing and systematizing the system. Before the final revised form and procedure was put into effect, certain nursing units adopted it for a trial period. Then a head nurse from one of these units, who was familiar with its use, presented the new system in class. By first acquainting the nursing staff with the changes in this procedure, we were able to institute the new system quickly and consistently throughout the hospital.

In the class given to familiarize the group with the admission and discharge procedures, questions in regard to hospital policies and administrative routines were voiced by the group. Most of these queries indicated a lack of understanding of interdepartmental relationships involved in carrying out the procedures. As a result, another class was conducted by the persons in charge of the reservation department and the business office. This class illustrated particularly the value of information being given directly by the individuals most capable of providing the correct explanation and interpretations. Following this class, better cooperation in facilitating the admission and discharge of patients was obtained.

Of equal importance in our program is the attitude of oneness evolving in the hospital when staff members get acquainted with people from other departments. Members of the staff have reported that information received in these classes helped them to answer questions from friends and relatives in the community.

As a part of the safety and fire program in our hospital, a quiz is given each month to the nursing personnel. After one of these quiz periods, many nurses expressed the desire for more specific information about the program. An inservice class, under the direction of the administrative officer in charge of the safety and fire program, was given as a result. The group was shown a movie that depicted the procedures we follow in preventing and in coping with fires. This was followed by a demonstration of the various types of fire extinguishers by another member of the safety and fire prevention committee. An opportunity for discussion proved beneficial to the committee and the group in solving problems in regard to this vital program. Again, getting to know the people in charge and being given adequate reasons for routines and procedures led to acceptance.

The respirator is most closely associated with poliomyelitis, but occasionally it is used for other types of illnesses. Consequently, the respirator has been installed in areas of our hospital where its management is less well known than in the polio unit. Incidents had occurred, as a result, in which patients' feelings of security, so important in this treatment, had been undermined because members of the staff conveyed their unfamiliarity in the performance of this treatment. In the weeks following a class demonstration of setting up the apparatus and caring for a patient in the respirator, nurses reported the satisfaction they derived from accomplishing this procedure so smoothly. The time saved by giving inclusive instruction was brought out in this class.

I have attended the workshop in the upstate New York area for the nationwide nursing aide program sponsored by the American Hospital Association, the National League for Nursing, and the Public Health Service. I received valuable assistance in planning and activating a training program for auxiliary workers. The education program for this group of workers is mainly confined to classroom demonstration and on-the-job training.

TOOK INVENTORY OF SKILLS

In determining a schedule of instruction, a skill inventory was developed which required a careful review and evaluation of procedures being performed by nursing aides and orderlies. A manual based on this analysis of skills is being organized as a teaching guide. Time and money may be saved by the hospital through developing procedures and planning instruction with consideration of the educational ability and background of these workers. This manual also affords a means of ensuring safe patient care by delineating areas of responsibility in performing procedures.

The need for organized training or retraining is greatest among the orderly group of auxiliary workers in our hospital. At present the work performance is being evaluated on the nursing units, and classes will be given according to specific needs. This approach to inservice training for auxiliary workers is aimed at providing inclusive training and retraining based on needs in promoting more effective patient care.

As a medical center in our area of the state, we have a high percentage of seriously ill patients requiring specialized types of care. New personnel coming to our hospital and staff mem-

bers rotating through the various services have frequently had little or no experience in giving some of this specialized care. Added to this is the fact that most of the time we have a full complement of patients requiring skilled care. The time element in acquainting new and rotating personnel with routines and technics is most important. Future inservice classes will be devoted to explaining new and revised routines and procedures. The development of a guide as a means of assisting both the person to be oriented and those directly responsible for orienting seems to be the answer in providing such a program.

A tour of the hospital and of each clinical unit affords an excellent opportunity for acquainting new personnel with specific information about the physical setup and administrative details. In conducting the hospital tour, we encourage understanding and cooperation by explaining the staff education program.

In organizing an orientation program, the first step was development of check sheets for the various categories of nursing personnel. The skill inventory provides a basis for checking procedures performed by nursing aides and orderlies. An analysis of procedures performed by professional and practical nurses was made in developing check sheets for them. As each new staff nurse becomes familiar with and able to perform procedures as practiced in Albany Hospital, she places a check next to the procedures and the "teacher" enters her initials. Since various individuals on the nursing unit cooperate in orienting new staff nurses, the check sheets aid in avoiding unnecessary repetition and in ensuring quicker and more inclusive orientation. The need for special instruction may also be determined by a review of these check sheets.

Many of our new staff nurses have had little or no opportunity to learn some of the specialized treatments and procedures performed at Albany Hospital. The check sheets and guide are arranged so that each nurse can become acquainted with more familiar procedures as practiced here first. Our new staff members, as a rule, say that as soon as they can begin caring for patients they feel more comfortable and at home. This arrangement for orientation facilitates their carrying out patient care assignments while gradually learning more complex technics.

In offering an opportunity for professional growth, our hospital has made available for its professional staff a course in ward management and teaching sponsored by Russell Sage College. Another opportunity is provided for head nurses and staff nurses in the teaching of inservice classes. Future plans include acquainting the staff with hospital and community opportunities for advancement.

An orientation program for new and rotating medical students and house doctors is also being considered here. The main objective is to acquaint these staff members with the physical setup of the hospital and clinical units and with the nursing organization and practices. Throughout the staff education program, planning is directed toward promoting satisfactory work situations and conditions to create esprit de corps in the hospital.

An important part of any program is effective follow-up work and supervision. Expected achievements point to the areas of evaluation and supervision. As has been stated previously, our goals are better work performance, inclusive instruction in the hospital, improved methods and procedures, improved attitudes and understanding toward administrative policies, improved community relations through changed employe attitudes, and improved work situations and satisfaction. As a help in evaluating the effectiveness of our inservice program, a survey was made recently. One of the comments received was: "Many people feel that learning ends with the end of training. This program makes us conscious of the fact that learning is constant."

Many comments were made to the effect that the classes had promoted greater uniformity in routines and procedures throughout the hospital and had provided answers to questions about old and new procedures and policies. Also, such noteworthy points of view were revealed as: "thankful to be connected with such a progressive hospital," and "shows administration is interested in the staff and ultimately patients."

It is evident that the staff appreciates and is profiting from the program. By instituting an educational program planned to meet ever changing situations and conditions, Albany Hospital is facing the obvious needs of its staff and the community.

How a Layman Defines a Nurse

A nurse is: the gentle touch that soothes a fevered brow, a kindly beacon in the fog of delirium, a wise and knowing hand that transforms anguish into blessed sleep!

A nurse has: arms that can tenderly cradle a newborn child, or give supporting comfort to a wounded soldier far from home; the resolute voice of youth, when first she proudly repeats the pledge of Florence Nightingale, and vibrant tones that take on added richness with the maturity of years.

Her beauty is: the true beauty that stems from an inner loveliness of spirit.

The language she speaks is: a universal language that knows no barriers of nationality or tongue.

A nurse is: a quick step in a dim corridor at night; a crisp silhouette of hope, as the ambulance sirens wail; the quiet competence that dispels hysteria and panic in the sickroom; the watchful sentinel through the long vigil when the spark of life is low.

Hers are: the swift, sure movements of the trained technician in the operating room, and a resourceful ingenuity pitted against the elements in the disaster area.

A nurse is: a delicate combination of skills and trained intuition, ministering to the physical, the emotional, and the spiritual needs of those in her care, knowing the interdependence of spiritual well-being and physical recovery and the balance between scientific skills and the benevolence of the Divine Healer.

Untiring in her zeal, unwavering in purpose, and firm in the exercise of her duties, **the nurse encourages** her patient, step by step, along the road to recovery—or, if God ordains, to a happy reunion with Him in the life beyond.

A nurse is: the dedicated embodiment of God's own concept of mercy.
—ARTHUR DIMOND, *advertising manager, H. J. Heinz Company, in a graduation address at Ohio Valley General Hospital, McKees Rocks, Pa.*

ABOUT PEOPLE

Administrators


Arkell B. Cook

Arkell B. Cook, administrator of Evanston Hospital, Evanston, Ill., since March 1949, has been named administrator of Butterworth Hospital, Grand Rapids, Mich., succeeding **Edward E. James.** Before going to Evanston, he served as administrator of Garfield Hospital, Washington, D.C., superintendent of Monmouth Memorial Hospital, Long Branch, N.J., and assistant director of the University Hospital, Ann Arbor, Mich. He is a member of the American Hospital Association and the American College of Hospital Administrators. Mr. Cook was elected first vice president of the Illinois Hospital Association at its annual meeting in January. Recently he completed his term of office as president of the Chicago Hospital Council.

Dr. Joseph Lichty has been appointed executive director of Akron General Hospital, Akron, Ohio, succeeding **Eva P. Craig,** who will retire June 1 after nearly 25 years at the Akron hospital. Dr. Lichty formerly was administrator of Moses H. Cone Memorial Hospital, Greensboro, N.C., and has been assistant dean of Harvard Business School and of Harvard Medical School.

Edna M. Hayward has announced her resignation as administrator of Benjamin Stickney Cable Memorial Hospital, Ipswich, Mass. Miss Hayward, who is retiring after 36 years of active hospital administration work, served as administrator of Wessen Maternity Hospital, Springfield, Mass., for 26 years. She is a fellow of the American College of Hospital Administrators, a member of the American Hospital Association and the National League for Nursing, and a member and former trustee of the Massachusetts Hospital Association.

Robert Stone has assumed the position of assistant administrator of the Griffin Hospital, Derby, Conn. He was formerly an assistant director at the Jewish Hospital of St. Louis, and is a graduate of the program in hospital administration at Columbia University.

Dr. Morris A. Jacobs has been appointed New York City Commissioner of Hospitals, succeeding **Dr. Basil C. MacLean,** whose resignation and appointment as president of the national Blue Cross Association were announced in the January issue of The Modern Hospital. Dr. Jacobs has been deputy commissioner of hospitals since September 1955, when he took a leave from his post as general medical superintendent of the hospital department. He also is deputy director in the medical emergency division of the city's office of civil defense. Dr. Jacobs studied at New York University Medical College and received his medical degree from New York University-Bellevue Medical College. He is a member of the American College of Hospital Administrators, the American Public Health Association, and a vice president of the Masonic Foundation for Medical Research and Human Welfare, New York State.


Robert A. Anderson

Robert A. Anderson has been appointed assistant director of the Sloan Institute of Hospital Administration and assistant professor of hospital administration in Cornell's graduate school of business and public administration. Mr. Anderson has been superintendent of the Wyoming County Community Hospital, Warsaw, N.Y., since 1948 and is president of the Health Association of Wyoming County, Inc. He is a graduate of Columbia University's program in hospital administration and a fellow of the American College of Hospital Administrators.


Charles B. Womer

Charles B. Womer has been named assistant director of University Hospitals, Cleveland, to develop personnel activities further. He will continue as administrator of Calvina McDonald House and Babies and Children's Hospital. Mr. Womer received his master's degree from Columbia University's school of public health and is a member of the American Hospital Association and the Ohio Hospital Association.

William E. Barron, administrator of Shadyside Hospital, Pittsburgh, has announced his retirement, to become effective May 31.

Norman L. Ryburn has been appointed administrator of the Man Memorial Hospital, Man, W.Va., one of the Miners Memorial Hospital Association group established by the United Mine Workers. A graduate of the hospital administration program at the University of Minnesota, Mr. Ryburn formerly was night superintendent of Hillcrest Medical Center, Tulsa, Okla. At the same time it was announced that **Harold C. Parks** will become administrator of McDowell Memorial Hospital, McDowell, Ky., another U. M. W. hospital. Previously, Mr. Parks was administrator of Wooster Community Hospital, Wooster, Ohio. He received his degree in hospital administration from Columbia University.

Richard E. Holden has been appointed administrator of Morrow County Hospital, Mount Gilead, Ohio, succeeding **Richard W. Claar,** who has been named administrator of Jane M. Case Hospital, Delaware, Ohio. Mr. Holden formerly was business manager of Cleveland City Hospital, Cleveland.

Ernest L. Pritt has been named administrator of Meyersdale Community Hospital, Meyersdale, Pa., following the resignation of **Harry Habel.** Mr. Pritt previously was assistant administrator of the Meyersdale hospital.

Kenneth P. Cohen, administrative assistant in management engineering at the Jewish Hospital of St. Louis for the last two years, has been named an assistant director of the hospital.

Willie G. Hinson has been appointed administrator of Jackson Hospital, Marianna, Fla. Prior to this appointment Mr. Hinson was administrator of the Mitchell County Hospital, Camilla, Ga., where he served as vice president of the Northwest Georgia Hospital Council and as a member of the auditing committee for the Georgia Hospital Association.

(*Continued on Page* 182)

PROTOTYPE STUDY: 600 BED HOSPITAL

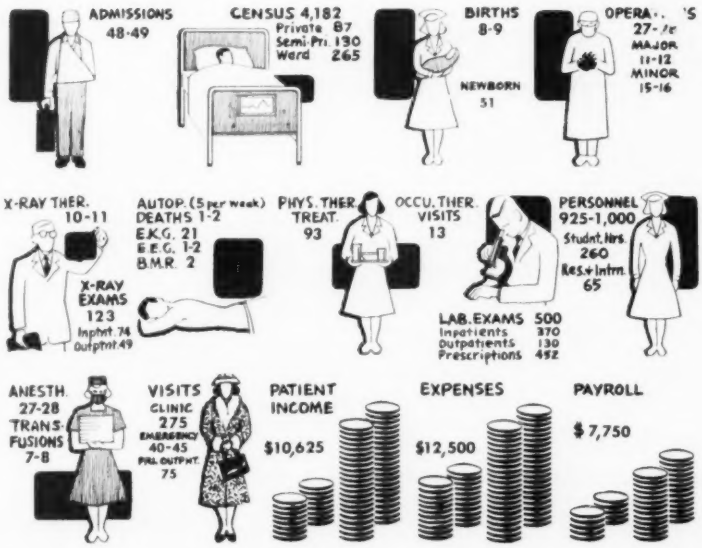
Concluding the series of "prototype studies" of hospital operations and activities, with up-to-date information on principal departments

This expanded prototype study of the 600 bed hospital analyzes operations in greater detail than has ever been done before. The prototype study becomes a useful tool for self-evaluation by hospitals in this size group, and a guide to administrative planning

LOUIS BLOCK, Dr. P.H.
Chief, Research Grants Branch
Division of Hospital and Medical Facilities
Public Health Service, Washington, D.C.

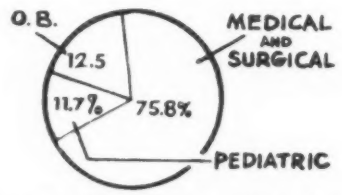
AN AVERAGE DAY'S ACTIVITIES

In this prototype of hospital operation for the 600 bed nonprofit, general hospital, national data were used whenever available. Regional, state or special group information was adjusted to the national basis. This represents the composite or average of existing statistical data. As new or more refined information becomes available, the content may need revision. It does not generally reflect affiliated services with other hospitals and sources; nor does it necessarily indicate the ideal institution.



BED DISTRIBUTION

In more than half of these hospitals, medical, surgical, obstetrical and pediatric patients have beds specifically set aside for their use. For this reason they are considered as major services to such a hospital type and size group. The foregoing bed distribution will be affected by assignments to additional services discussed hereafter:



It is difficult to segregate medical and surgical beds because it is common practice to have combined medical-surgical nursing units.

The bed distribution by type of accommodation may vary considerably, dependent upon the indigent relationship. Ward beds, however, account for about 50 to 60 per cent of all available beds.

In addition to the basic grouping of patients found in more than half of these hospitals, the 600 bed, nonprofit, short-term, general hospital may make specific bed assignments for other patient groups. Because they occur in less than half of these hospitals they are considered as additional service groupings. The following shows these additional service groupings, frequency of occurrence, and average number of beds assigned them:

ISOLATION OR CONTAGIOUS PATIENT BEDS—
- a. Frequency of occurrence ..... 3 in 10 hospitals
- b. Average number of beds assigned 22

CHRONIC (LONG-TERM) PATIENT BEDS—
- a. Frequency of occurrence ..... 1 in 18 hospitals
- b. Average number of beds assigned 66-67

NERVOUS AND MENTAL PATIENT BEDS—
- a. Frequency of occurrence ..... 1 in 3 hospitals
- b. Average number of beds assigned 78

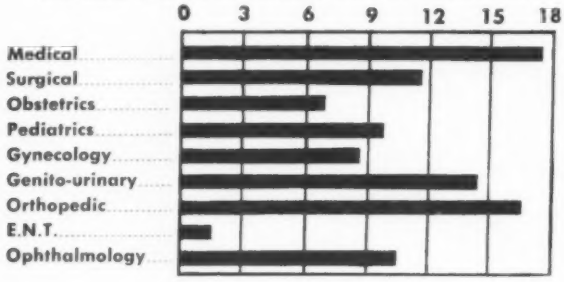
TUBERCULOSIS PATIENT BEDS—
- a. Frequency of occurrence ..... 1 in 6 hospitals
- b. Average number of beds assigned 35

UTILIZATION

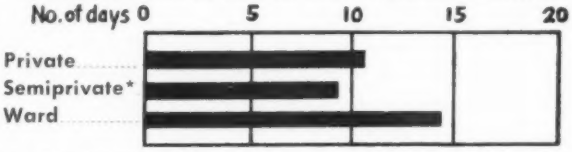
The kind, type and number of patients admitted to and using the 600 bed general hospital are as follows:

Annual number of adult admissions	17,800-17,900
Annual number of admissions per bed	30
Annual number of live births	3,100
Annual number of premature births	175-180
Annual number of sets of twins	30
Annual number of sets of triplets	2
Percentage of adult occupancy	80
Percentage of newborn occupancy	68
Average length of patient stay	10-11 days
Annual number of patient days of care	176,000
a. Private patient days	31,680
b. Semiprivate patient days	47,520
c. Ward patient days	96,800
Annual number of newborn infant days of care	19,000
Average daily adult census	482
a. Private	87
b. Semiprivate	130
c. Ward	265
Average daily newborn census	51

AVERAGE LENGTH OF PATIENT STAY BY DIAGNOSIS:



AVERAGE LENGTH OF PATIENT STAY BY ACCOMMODATION:



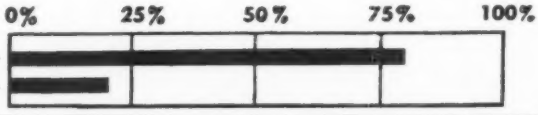
*Semiprivate patients usually stay a shorter time than do either private or ward patients. Among the usual explanations for such an occurrence is that the pressure of finances requires the semiprivate patient to get back to gainful employment as soon as possible. Private patients may be in a better position to afford slightly longer convalescence in the hospital. Ward patients, on the other hand, may have other factors dictating or affecting the length of time they stay. Among them are usually those of more advanced cases of illness and home conditions not conducive to convalescence.

FINANCIAL

Total annual expenses	$ 4,550,000	% payroll of total expenses	62	% patient income of total	85
Total expenses per patient day	$25.75-$26.00	Total annual income	$ 4,550,000	Total assets	$12,500,000
Average expenses per patient stay	$ 275	Total income per patient day	$ 26.00	Total assets per bed	$ 20,834
Annual payroll	$ 2,825,000	Annual patient income	$ 3,875,000	Plant assets	$ 7,000,000
Payroll per patient day	$ 16.00	Patient income per patient day	$ 22.00	Plant assets per bed	$ 11,667
				% plant assets of total assets	56

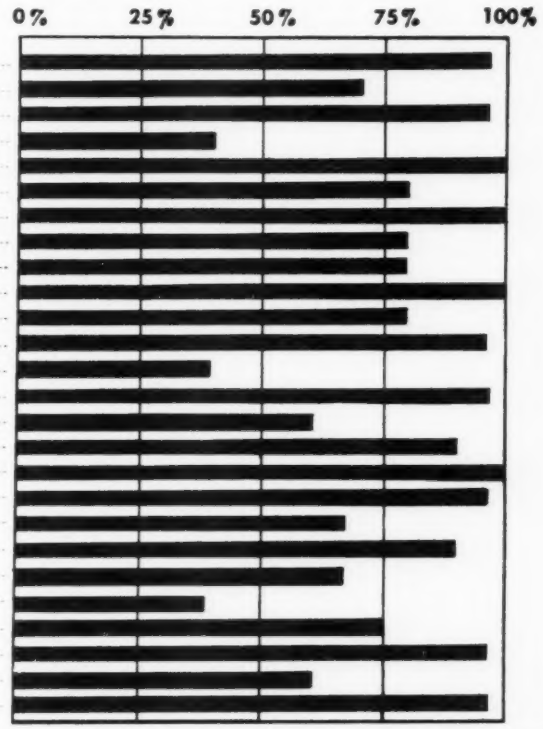
NURSERY

NUMBER OF BASSINETS 75



SERVICES

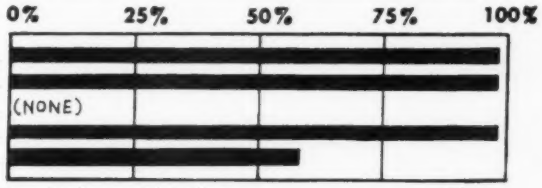
Services which might be provided but which are generally found to occur in less than 50 per cent of the facilities of this size group are considered as additional. Certain of these services may be provided through arrangements with other hospitals and sources. Such arrangements are not reflected in the frequencies shown.



Frequency of hospitals offering:

- Blood bank
- Cancer clinic
- Central supply room
- Children's educational program
- Clinical laboratory
- Dental department
- Electrocardiograph
- Electroencephalograph
- Hospital auxiliary
- Library, medical
- Library, patient
- Medical records department
- Mental hygiene clinic
- Metabolism apparatus
- Occupational therapy department
- Outpatient department
- Pharmacy
- Physical therapy department
- Postoperative recovery room
- Premature nursery
- Radioactive isotopes
- Rehabilitation department
- Social service department
- X-ray diagnosis
- X-ray, routine chest on admission
- X-ray therapy service

RADIOLOGY

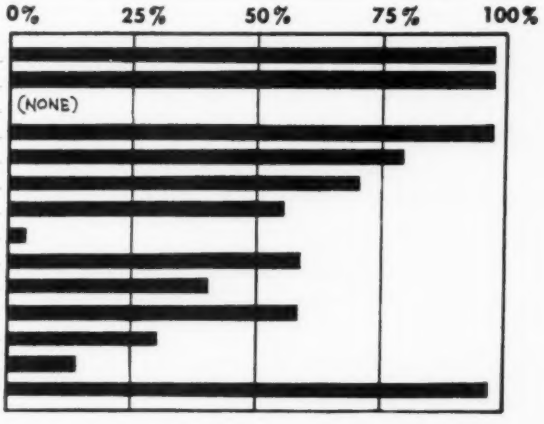


Frequency of hospitals having:

- Physician staff members specializing in radiology
- Physician staff members specializing full time in radiol.
- Physician staff members specializing part time in radiol.
- X-ray facilities available to priv. amb. patients of phys.
- Chest x-ray on all admissions

X-ray examinations, annually	45,000
a. Annual inpatient x-ray examinations	27,000
b. Annual outpatient x-ray examinations	18,000
Patients seen, annually	37,350
Examinations per inpatient	1.2
Films taken annually	112,500
Films per examination	2.5
X-ray therapy treatments annually	4,000

LABORATORY



Frequency of hospitals having:

- Physician staff members specializing in pathology
- Physician staff members specializing full time in path.
- Physician staff members specializing part time in path.
- All tissue removed at surgery routinely examined by path.
- Urinalysis on all admissions
- Blood count on all admissions
- Serological examination for syphilis on all adult admissions
- E.K.G.'s on all admissions over 45 years of age
- Rh grouping on all pregnancy cases
- Preoperative blood grouping on all surgical cases
- Preoperative coagulation on all tonsillectomies
- Postoperative urinalysis on all surgical cases
- No tests without doctors' orders
- Lab. facilities available to priv. amb. patients of physicians

Annual clinical laboratory examinations	180,000
a. Annual inpatient laboratory exams	135,000
b. Annual outpatient laboratory exams	45,000
Annual electrocardiograms	7,500
Annual electroencephalograms	400
Annual basal metabolism exams	700
Annual blood transfusions	2,750

PERSONNEL

DEPARTMENTAL DISTRIBUTION OF PERSONNEL:

ADMINISTRATION	10-11	HOUSEKEEPING	65-71	PHARMACY	8-9
BUSINESS OFFICE	62-66	DIETARY	130-143	PHYSICAL THERAPY	6-7
PURCHASE AND STORES	14-15	NURSING	308-340	MEDICAL RECORDS	18-20
PLANT OPERATION	37-41	NURSING EDUCATION	20-22	SOCIAL SERVICE	15-17
MAINTENANCE OF BLDG. AND GRDS.	29-32	OPERATING ROOMS	40-45	OUTPATIENT DEPARTMENT	40-44
		DELIVERY ROOMS	15-16	EMERGENCY	7-8
LAUNDRY	29-32	ANESTHESIA	10	OTHER PERSONNEL	20-25
LINEN AND SEWING	11-12	X-RAY DIAG. AND THERAPY	27-30	INTERNS AND RESIDENTS	65
MAINTENANCE OF PERSONNEL	48-53	LABORATORY	42-46		

Number of full-time personnel 1,080
Number of full-time personnel per 100 patients 222
Number of full-time employes per bed 1.8
Number of full-time employes per occupied bed 2.2
Hospitals having volunteers other than women's auxiliary ..... 9 in 10
For those hospitals having volunteers, average number per hospital 122
Hospitals having a women's auxiliary ..... 4 in 5
For those hospitals having a women's auxiliary, average number of members per hospital 730
Average number of members of women's auxiliary working in the hospital 143

Nursing personnel:

a. Total graduate nursing personnel 232
   (1) Administrative graduate nurses 6-7
   (2) Full-time instructors 11-12
   (3) Supervisors and assistants 18
   (4) Head nurses and assistants 44-45
   (5) General duty nurses full-time 110-111
   (6) General duty nurses part-time 42-43
b. Private duty nurses 61
c. Practical nurses 39
d. Student nurses 260
e. Attendants 52
f. Nurse's aides 101-102
g. Ward aids 29-30
h. Orderlies 41-42

Medical technologists:

a. Registered full-time 10-11
b. Registered part-time 1
c. Other full-time 21
d. Other part-time 3

X-ray technicians:

a. Registered full-time 5
b. Registered part-time 0
c. Other full-time 5
d. Other part-time 0

Pharmacists:

a. Full-time 4-5
b. Part-time 0-1

Medical record librarians:

a. Registered full-time 2
b. Registered part-time 0
c. Other full-time 1-2
d. Other part-time 0

Other medical records personnel:

a. Full-time 17
b. Part-time 2-3

Dietitians:

a. Full-time 10-11
b. Part-time 0

Occupational therapists:

a. Registered full-time 2
b. Registered part-time 0
c. Other full-time 0-1
d. Other part-time 0

Physical therapists:

a. Registered full-time 3-4
b. Registered part-time 0-1
c. Other full-time 1-2
d. Other part-time 0

Medical social workers:

a. Full-time 9
b. Part-time 0-1

OPERATING AND DELIVERY ROOMS

Number of operating rooms 10
Annual number of operations 10,000
a. Annual number of major operations 4,300
b. Annual number of minor operations 5,700
Number of delivery rooms 3
Annual number of deliveries 3,100
Annual number of anesthetics 10,000

OUTPATIENT DEPARTMENT

Number of annual clinic visits 100,000
Number of annual private outpatient visits 27,500
Number of annual emergency visits 15,500

PHARMACY

Hospitals having formulary ..... 7 in 10
Hospitals operating pharmacies ..... All
Of those hospitals operating pharmacies, having full-time licensed pharmacist ..... Almost all
Of those hospitals having full-time pharmacists, average number 4-5
Of those hospitals operating pharmacies manufacturing parenteral solutions ..... 1 in 5
Annual number of prescriptions 165,000

MEDICAL RECORDS

Hospitals microfilming medical records ..... 2 in 3
Annual number of deaths 524
Per cent deaths of admissions 3.0
Annual number of autopsies 258
Per cent autopsies of deaths 49
Annual number of deaths released to legal authorities 50
Per cent such deaths (6) of admissions 0.3
Annual number of stillbirths 35
Annual number of premature fatalities 29-30

He's paid the bill. He's as good as new. But he may never give you a dime for your hospital, your new convalescent wing — or anything else. Something went wrong — and it will take professional help to cure it! This article tells how you can.

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hospital

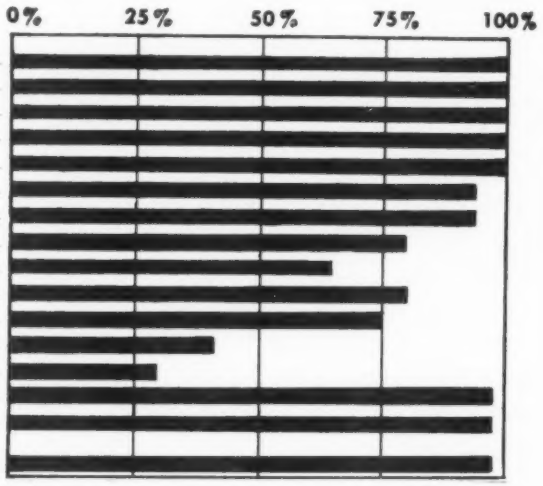
administrator

street

city/state

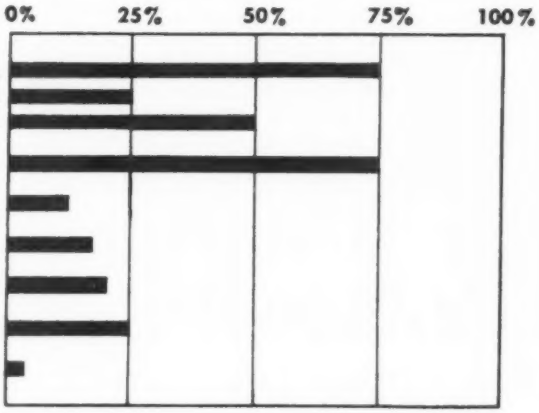
MEDICAL STAFF

Frequency of hospitals having:



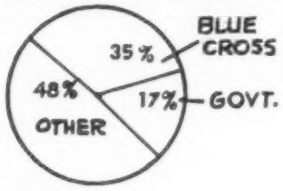
- CHIEF OF STAFF
- CHIEFS OF SERVICES
- WRITTEN STAFF REGULATIONS
- REGULAR STAFF MEETINGS
- STANDING STAFF COMMITTEES
- EXECUTIVE STAFF COMMITTEE
- MEDICAL RECORDS COMMITTEE OF STAFF
- CREDENTIALS COMMITTEE OF STAFF
- TISSUE COMMITTEE OF STAFF
- EDUCATION COMMITTEE OF STAFF
- PHARMACY COMMITTEE OF STAFF
- DIETARY COMMITTEE OF STAFF
- NURSING COMMITTEE OF STAFF
- PSYCHIATRIST ON STAFF
- SURGICAL RESTRICTIONS ON STAFF
- RECEIVED ACCREDITATION BY THE JOINT COMMISSION ON HOSPITAL ACCREDITATION

ACCOUNTING



- Hospitals which calculate depreciation
- Hospitals which operate under formal budgets
- Hospitals which use A.H.A. chart of accounts
- Hospitals which fund depreciation (of those hospitals which calculate depreciation)
- Hospitals which have inclusive rate for all patients
- Hospitals which have inclusive rate for obstetrical patients
- Hospitals which have inclusive rate for tonsillectomy patients
- Hospitals which charge for drugs carried in stock on nursing unit
- Per cent of hospital billed income which is considered uncollectible

PER CENT OF BILLED CHARGES PAID



STARTING MONTHLY SALARY:

General duty nurse	$262
Untrained women	159
Untrained men	170
Clerks	179
Practical nurse	189

HOURS OF WORK PER WEEK:

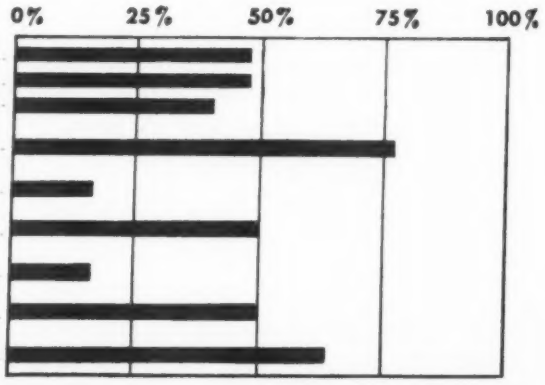
General duty nurse	41
Untrained women	43

AVERAGE ROOM RATES:

One-person room	$17.85
Two-person room	14.20
Multibed room	12.10

AVERAGE DAYS OF VACATION AFTER ONE YEAR OF EMPLOYMENT:

General duty nurse	15
Untrained women	13



- Hospitals paying general duty nurses extra pay for:
  - a. Evening shift
  - b. Night shift
- Hospitals paying overtime in cash
- Hospitals offering automatic salary increases to general duty nurses
- Hospitals offering complete maintenance to general duty nurses
- Hospitals offering no maintenance to general duty nurses
- Hospitals offering complete maintenance to untrained women
- Hospitals offering no maintenance to untrained women
- Hospitals requiring advance deposits from patients responsible for own bill

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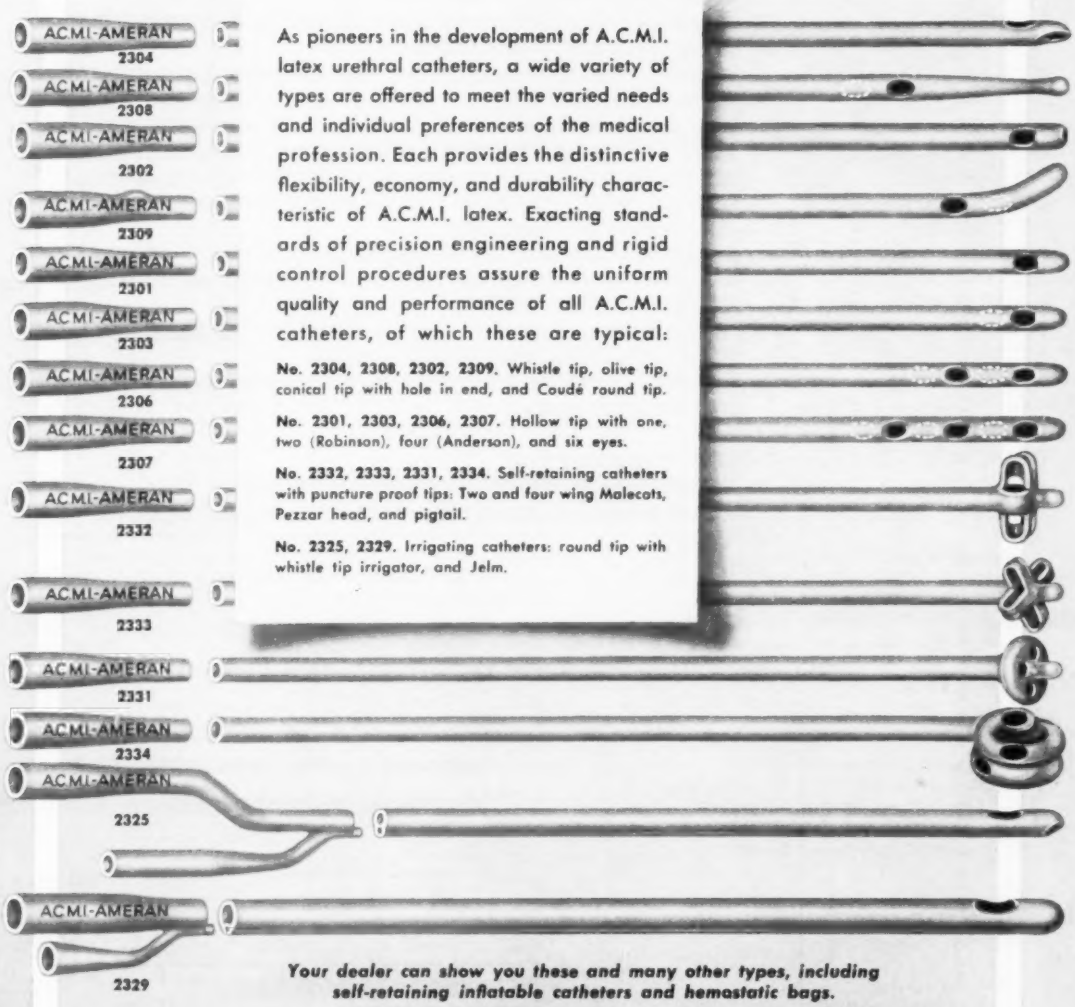
LATEX URETHRAL CATHETERS

by A.C.M.I.—to meet varied requirements



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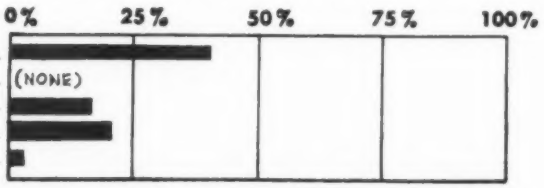
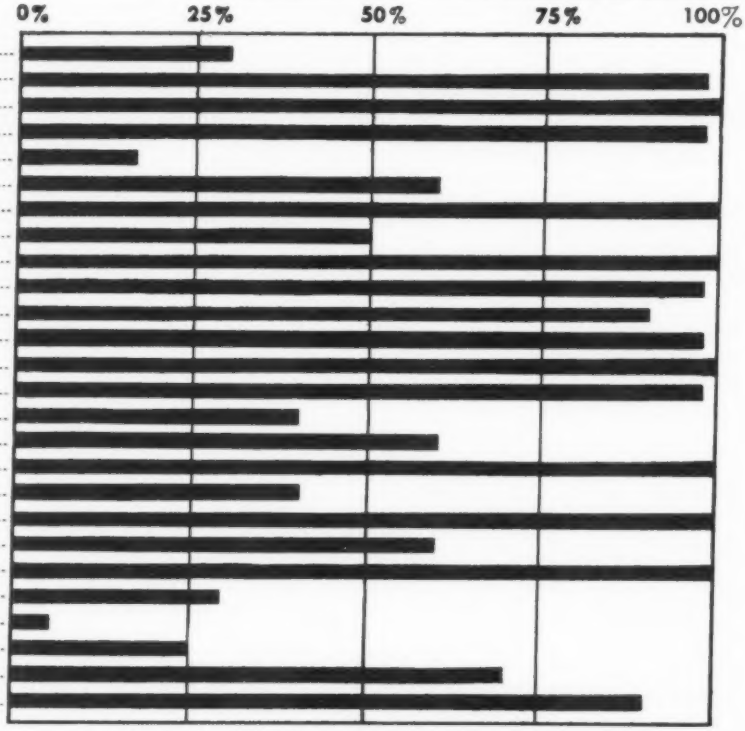
ADMITTING

Frequency of hospitals:



Routinely treating:



Admitting psychiatric patients ..... 3 in 5

Of those general hospitals admitting psychiatric patients:

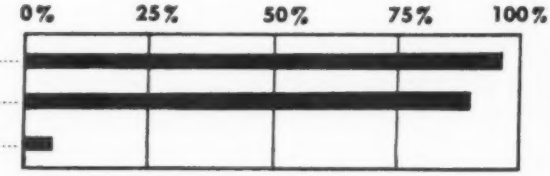
a. Caring for such patients in separate buildings ..... 1 in 8

b. Caring for such patients in separate departments in same building ..... Almost 2 in 3

c. Caring for such patients in no separate facilities ..... 1 in 4

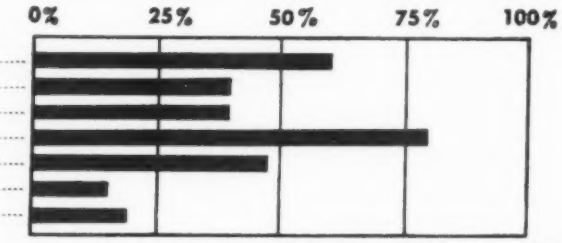
PURCHASING

Frequency of hospitals with:



RELIGIOUS

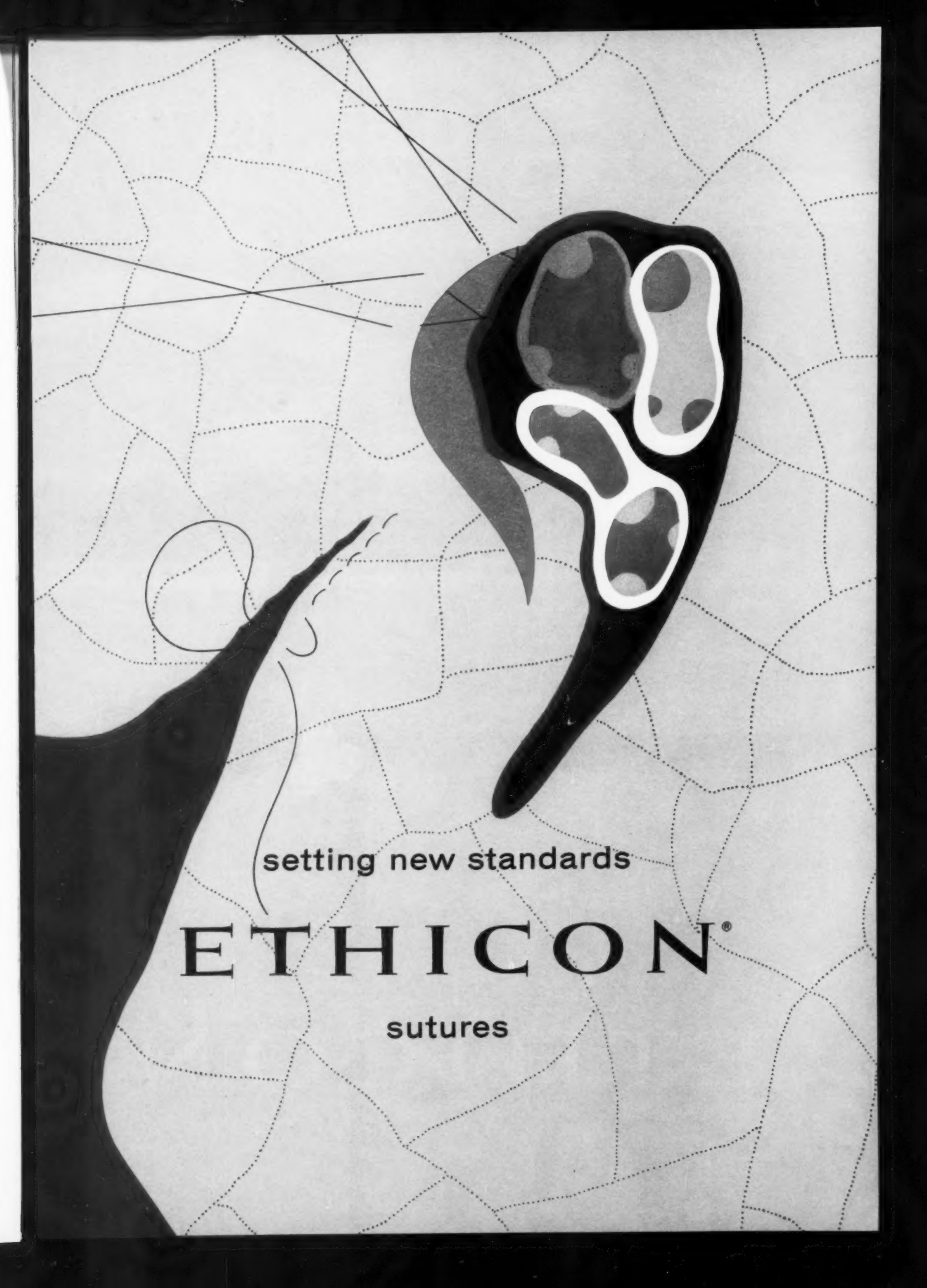
Frequency of hospitals with:



PHYSICAL AND OCCUPATIONAL THERAPY

Annual physical therapy exams 34,000

Annual occupational therapy visits 4,725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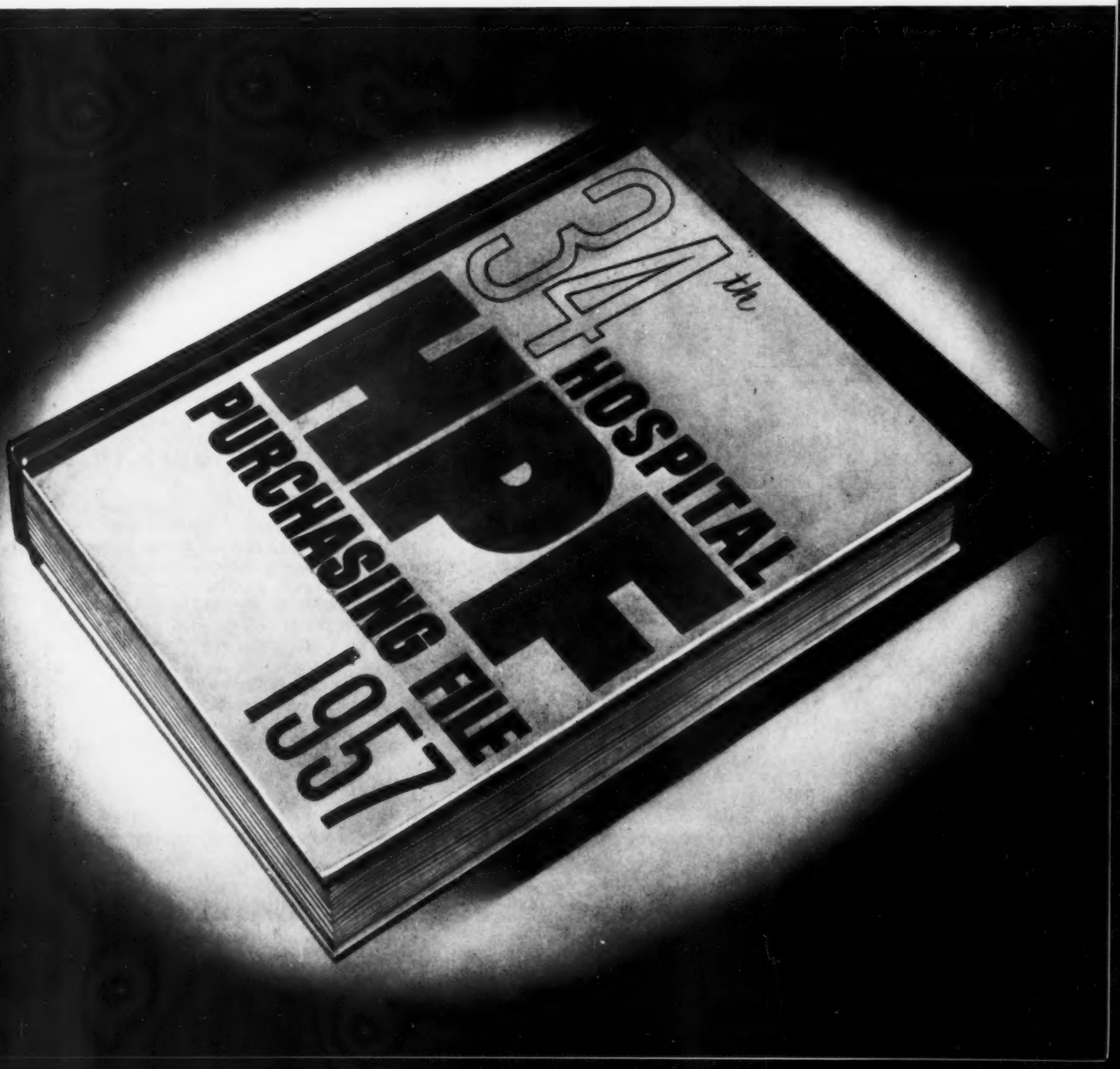


ADMINISTRATOR

Frequency of hospitals:

	0%	25%	50%	75%	100%
Having administrative staff member on duty at night					
Delegating administrative responsibility to night supervising nurse					

DIETARY

NUMBER OF MEALS SERVED ANNUALLY	1,045,000	a. Patients	520,000
		b. Employes and other	525,000

PUBLIC RELATIONS

Frequency of hospitals using:

Booklet for employes	3 in 5	Patient opinion poll	3 in 5
Booklet for patients	3 in 4	Personnel opinion poll	1 in 7
Regularly published house organ	3 in 5	Medical staff opinion poll	1 in 10
Printed annual report	3 in 5	Community opinion poll	1 in 25
		Using no such polls	1 in 3

SAFETY

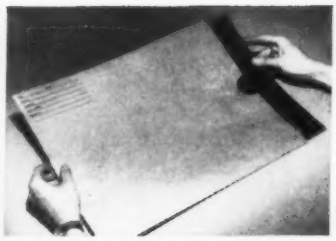
Frequency of hospitals with:

Organized safety committee	7 in 10	Own written plan for mobilization of employes and medical staff	4 in 5
Written fire emergency and evacuation plans	4 in 5	Written mobilization plan integrated in master community plan	2 in 3
Regularly scheduled fire drills	1 in 2	Representation on a community disaster planning committee	4 in 5

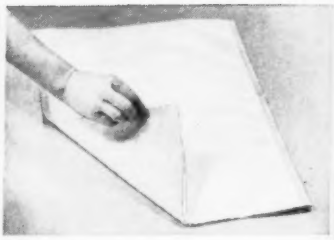
LAUNDRY

Hospitals which operate own laundry and process all soiled linen	9 in 10	part of soiled linen	1 in 18
a. No. of lbs. processed per week	50,500-51,000	a. No. of lbs. processed per week	43,000-43,250
b. Number of lbs. processed per patient day	15-16	b. Number of lbs. processed per patient day	14-15
c. Number of lbs. processed per year	2,626,000-2,652,000	Hospitals which do not operate own laundry	1 in 33
Hospitals which operate own laundry and process only a		a. No. of lbs. processed per week	27,000-27,250
		b. Number of lbs. processed per patient day	10-11

URINAL COVER
white opaque; flushable



X-RAY FILM STORAGE ENVELOPE
new, thinner paper saves storage space



BED PADS
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PURO-CAP NIPPLE COVERS
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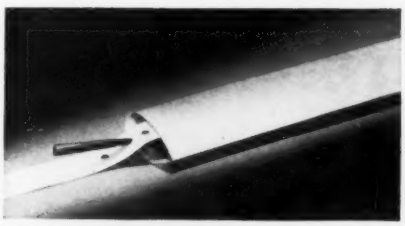

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How to Give Oxygen Therapy by Tent

The nursing staff does the best job of controlling administration of oxygen by tent, this study shows

ALEX M. BURGESS, M.D., and M. LUCIA EAGAN, R.N.

EXPERIENCE in checking the use of oxygen in other hospitals led us at Newport Hospital, Newport, R.I., to the opinion that therapy by tents was often inefficient and highly expensive. In many hospitals it had been found that proper analyses of the oxygen content of the air in tents were not being made. A check of such tents often showed that the patient was actually receiving less than 30 per cent oxygen despite the fact that the flow into the tent was at a rate of 8 to 12 liters per minute. On the other hand, records at Newport Hospital, where testing of oxygen content of air in tents is regularly done by the nursing service, gave much more favorable figures. It seemed worth while, therefore, to check the accuracy of our work here to see if the favorable reports are supported by results from further testing, and to consider whether or not our treatment methods should be changed.

IT IS AN EXPENSIVE METHOD

At best, oxygen therapy is expensive. This is particularly true of the use of tents in which, for adults at least, it is often necessary to employ a flow of 10 liters per minute. This rate of flow results in the use of about two cylinders of oxygen in 24 hours at an approximate cost of $11 per day. Such an expense is, of course, justified only if the apparatus is efficient and the patient is actually receiving oxygen in the optimum therapeutic concentration which, for most clinical conditions, is from 45 to 60 per cent.

When we realize that 2761 large cylinders of oxygen, at a cost of $7,427.09, were used at this hospital in 1955 plus an additional $733.66 for oxygen in other types of cylinders, or a total of $8,160.75 for all oxygen used, an inquiry into the efficiency with which it is being used seems well justified.

It may also be appropriate to mention that it is a temptation to the physician to order oxygen therapy for patients who have Blue Cross coverage because he thinks it might be of some help or comfort to the patient even if a definite need for it cannot be demonstrated.

For these reasons, a limited study of the use of oxygen was planned and carried out as follows:

As a preliminary step, samples of air from tents in operation were taken at three different points in each tent to determine whether or not the method recommended by the manufacturers gave an accurate estimate of the oxygen content of the air the patient was breathing.

When this had been determined, regular tests were carried out by the nursing department and the results were charted, with a note as to the rate of flow of the oxygen.

The clinical diagnosis was noted and the records were studied in every instance to determine as far as possible whether or not a real need for the use of oxygen existed. In some instances this matter was discussed with the attending physician but usually the situation could be accurately judged from the records.

Although several of the principal methods of applying oxygen therapy as described in standard texts (see References[1,2,3]) are used in this hospital, during the period of the study it was given by tent only, except for very short periods in which oronasal insufflation by catheter was used.

MUST PREVENT LEAKS

To give oxygen efficiently by tent, leaks must be prevented and the mattress must be covered by an impermeable sheet of some sort. Because of the necessity to keep the skirts of the canopy well tucked in and because of leaks created by the movements of a restless patient, some students of oxygen therapy feel that it is futile to try to give oxygen in tents, unless the patient is attended by special nurses. Our study makes it clear that this is not the case.

The preliminary study of the oxygen at different points in the tents was carried out by taking samples (1) from a point just above the bridge of the patient's nose; (2) from the lowest point in the tent from which samples could be obtained, and (3) from the outlet cock as recommended by the manufacturers.

The samples from inside the tent were withdrawn by means of a metal tube attached to the plastic tube of the

Dr. Burgess is director of medical education and consultant in medicine at Newport Hospital, Newport, R.I. Mrs. Eagan is a clinical instructor in the hospital's school of nursing.

analyzer and by introducing this through a minute opening in the side of the tent canopy made by withdrawing the zipper just enough to allow passage of the rigid tube.

These tests were made more than 80 times and the results showed no consistent differences in oxygen content at the various points. In 75 per cent of the cases there was a variation of only 2 per cent, or less, among the three readings. Where the differences were greater than this, it was noted that the lowest reading was found at each of the three test points in an approximately equal number of instances, which suggested no consistent difference in the oxygen content at the three points but rather technical variations in carrying out the tests. Thus we concluded that the method of obtaining the sample at the testing cock as recommended by the manufacturers is satisfactory and all further testing was done in this manner.

Fifteen adult patients were given oxygen therapy by tent during a period of eight weeks. The average period of oxygen therapy was seven days. There were 116 days of oxygen treatment during which the concentration of oxygen was tested 589 times. Except for a few of the tests made by the authors while technics were being worked out, the tests were all made by members of the nursing staff in charge of the patients. An average of five tests was made on a patient in 24 hours.

In addition, three infants were treated in tents. However, although it was easy to maintain an adequate concentration of oxygen in these cases, the method is so relatively inefficient and wasteful that it does not seem necessary to discuss the details here. Other methods for treating children are preferable, we believe. This is especially true of the use of the open box.[4] It is applicable to infants and children (and even in treating adults it is in some respects preferable to the use of tents).

The diagnoses recorded on the records of the 15 patients studied are as follows:

Bronchial asthma	3
Pneumonia	3
Cancer of the lung	1
Intestinal obstruction	1
Cerebral thrombosis	1
Mitral valvular heart disease	1
Arteriosclerotic heart disease	5

A careful study of the records made it clear that the use of oxygen therapy for every one of these patients was justified. We believe that in no case was the treatment continued longer than it was needed, although there was one instance in which the patient developed a fear of being out of oxygen and treatment was continued with a very low flow until this fear could be overcome.

We found that the average concentration of oxygen was 50 per cent and the average oxygen flow was 8 liters per minute. Although in one instance it was necessary to employ a flow of 15 liters per minute in order to keep alive a patient with massive carcinoma of the lungs, in several patients a flow of 7 liters produced an adequate concentration of oxygen. These results are regarded as satisfactory and, in our judgment, can only be achieved by meticulous care on the part of those attending the patient.

Based on the favorable results reported here, it is our considered opinion that the most efficient manner in which to apply oxygen therapy by the tent method is to have it controlled by the nursing staff. Ward nurses under adequate supervision can discover

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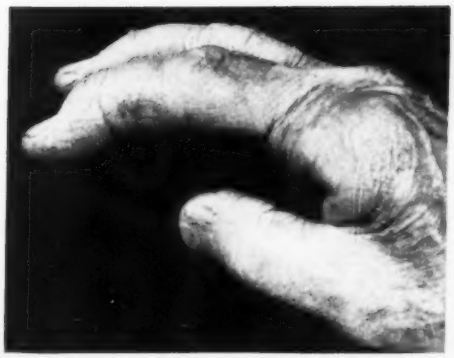

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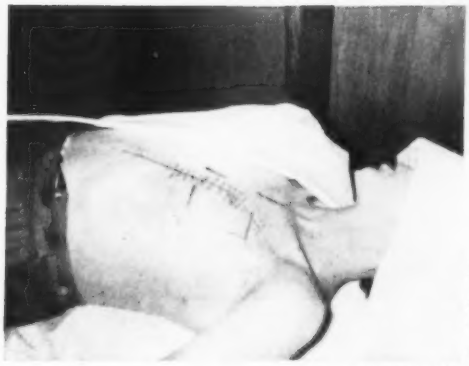

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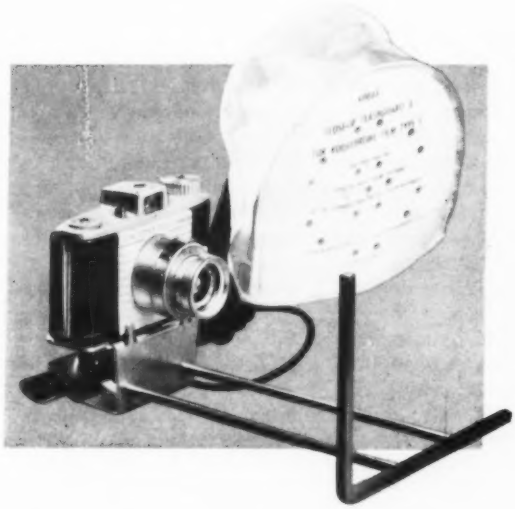

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quickly and correct any leaks or other reasons for inadequate oxygen content in the tents. When, on the other hand, the testing is done by an individual other than the nurse in charge of the patient, there is a division of responsibility which does not tend to a prompt correction of inefficient treatment.

SUMMARY AND CONCLUSIONS

1. In a study of 15 patients receiving oxygen therapy during a period of eight weeks at Newport Hospital, using a standard make of oxygen tent, the following facts were recorded:

Average duration of therapy—7 days

Average flow of oxygen—8 liters per minute

Average concentration of oxygen—50 per cent

2. The patients were adults suffering from various disease conditions and in every instance the use of oxygen therapy is believed to have been justified.

3. In the period of eight weeks, in which 116 days of oxygen therapy was applied to the 15 patients, 589 tests were made by the nursing staff, with an average of five tests per 24 hours per patient, and with the results in terms of liter flow and oxygen content noted heretofore.

4. It is our belief that these favorable results can only be achieved by placing the responsibility for the control of the treatment in the hands of those in immediate charge of the patient—the nursing staff.

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NOTES AND ABSTRACTS

Prepared by the Department of Pharmacology
Emory University, Georgia

Methods of Evaluating Therapeutic Agents in the Treatment of Schizophrenic Patients

THERE is little doubt that the "double-blind" method of evaluating therapeutic agents is the ne plus ultra in terms of experimental design. It seems to me, however, that in our present stage of knowledge certain practical aspects of the problem of testing drugs in mental patients cannot be ignored. As will be pointed out, these practical considerations oftentimes militate against the use of double-blind procedures, a fact that will be readily apparent to those experienced in drug testing in mental institutions. Further, as will also be illustrated, methods are available that allow valid assessment of the effectiveness of candidate therapeutic agents which do not require the use of double-blind procedures and which conform to the practical exigencies of the situation in most mental hospitals.

Working with Drs. Nathaniel Apter, T. Tausig, John Berry, Louis Schlan, Paul Feldman, George Zubowicz and others, I have been actively engaged in the treatment of chronic hospitalized schizophrenic patients since 1949. (The schizophrenic state cannot at present be accurately defined. Hospitalized patients bearing this label may, with further research, be subdivided into many new categories of diagnosis as specific etiologies are discovered.)

In 1952 a research ward was established at the Manteno State Hospital, Manteno, Ill., for the purpose of studying schizophrenia as it may be increased or decreased by enzyme inhibitors. From 60 to 80 patients have been available. The patients' relatives have signed experimental treatment permits. The ineffective drugs (frenquel, diamox, subconvulsant doses of hydrazides, privine, lithium acetate, nicotinic acid, meratran, pyridoxine, multivitamin capsules, I.V. histamine, morphine addiction, dihydroacetic acid, ammonium chloride, acetone, ethanol, photic stimulation, ACTH, cortisone, guanido acetic acid, dehydroisoandrosterone, BOL-148, isoniazid and iproniazid) have far outnumbered the partially effective therapeutic agents, which are ECT, convulsions produced by hydrazides, chlorpromazine, reserpine, growth hormone, 30 per cent CO_2, amobarbital, arecoline and the combination of l-tryptophane and choline orally. This last combination was tried in seven mild schizophrenics (without the double-blind test), hoping they would be made worse because of the possibility that some patients might synthesize bufotenin. Two of the patients, however, became remarkably better, and none of the rest had any increase in their schizophrenia!

This observation is mentioned to show that one can learn just as much in regard to the possible biochemical cause of schizophrenia by making institutionalized patients worse as by attempting to improve them. Furthermore, if a biochemical etiology of one type of schizophrenia is discovered, we will not need a double-blind test to validate the results if the investigator proceeds with sufficient biochemical insight to titer the patients up and down in their degree of schizophrenia. Actually, if a schizophrenic patient has withdrawn from the world and wants to be left alone, increased nursing care and interviews might make him more violent! Our patients frequently become violent, but we charitably as-

"Well, then, how about *en brochette?*"

---

cribe this to the disease rather than to the interviewer. (I shall be the first to admit, when it is proved, that deep in their subconscious mind they really want "tender loving care.")

We have made two investigations in chronic schizophrenic patients using the double-blind test procedure. Semicarbazide was used to produce grand mal convulsions in schizophrenic patients. Patients were chosen who had not responded to previous therapy (insulin coma, metrazol convulsions and/or electroshock therapy). The patients had all been hospitalized for more than two years but had not received effective therapy in the six months prior to treatment with semicarbazide. The patients were treated in small groups of 12 or 14 patients so that one-half received semicarbazide therapy and the remaining half received placebo medication, photic stimulation, and the increased nursing care the project involved. Results of therapy were evaluated under blind test conditions by clinical psychologists using the Malamud-Sands psychiatric rating scale.

Therapy consisted of 1.0 gram morning and night except that twice a week the patient was given from 3 to 5 grams of semicarbazide orally after breakfast. This large dose was sufficient to make the patient susceptible to a grand mal seizure when photic stimulation was applied at a frequency of from 14 to 20 flashes per second. The grand mal seizure evolved slowly from a variable period of myoclonus, and the onset to muscular rigidity is much slower than that usually produced by ECT. Duration of therapy was four weeks and entailed only 8 or 10 grand mal seizures. Thirty-seven patients received convulsive semicarbazide therapy and, as a control, 39 patients received the placebo regime.

Remission of schizophrenia occurred in 15 of the 37 patients treated. Of the 15 remissions, four patients were discharged, three were awaiting discharge, and eight relapsed. All of the patients receiving semicarbazide convulsive therapy showed some improvement. Only two of the 39 patients receiving the placebo regime showed any improvement, and in one this was sufficient to allow transfer to a work cottage. The placebo group received placebo tablets, photic stimulation, bi-weekly interviews, and increased nursing care, yet the impartial rating by the clinical psychologists failed to disclose a significant placebo effect. In addition, a third group of 72 patients failed to disclose any therapeutic effect from subconvulsant doses of the hydrazides.

A second blind experiment attempted to disclose any difference between convulsions produced by hydrazides and electricity. This was designed as a cross-over experiment in which eight patients received ECT and eight patients had an equal number of convulsions from thiosemicarbazide. The patients were interviewed blindly to determine onset, duration and degree of remission. When all patients had returned to their initial state the two groups were to be crossed-over so that the patients would serve as their own controls. The study failed because our therapy of both groups was too effective, and we waited several months for all of the patients to relapse to their initial state and by that time the evaluating team had been changed.

Thus, we have not used a double-blind test on our schizophrenic patients since 1954. We have, however, used the patients as their own controls—in that they have failed to respond to many medications. In our opinion, then, the schizophrenic patient who has been institutionalized for more than two

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[1] Ross, S.: Antibiotics Annual 1955-1956. New York, Medical Encyclopedia, Inc., 1956, p. 600.

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years will not respond to placebo therapy and increased nursing care. An active program that provides almost continuous treatment (most of which is ineffective) provides a constant check on the possibility of spontaneous remission in an individual patient.

STAGES OF NEW DRUG TRIAL

When a drug passes chronic toxicity and neuropharmacological tests in animals, we know a great deal about the drug in various animal species that cannot talk or get schizophrenia. We usually know nothing about this drug in man. The possible therapeutic effect in various mental disorders must be determined with a maximum degree of caution and safety. Since our present drugs are all toxic at therapeutic levels, the task of the investigator is essentially to determine the minimal toxic dose for man in a statistically reliable manner.

The animal data are not transferable to man even with chemical congenors of compounds which have had human trials. (NP-207 produces retinitis in man while CPZ presumably does not.)

After producing decerebrate rigidity simultaneously in five epileptic patients with a new anticonvulsant, we decided that we would never again have a group of patients on the same increased dose of a new drug. We now select a cooperative[1] pioneer patient who is methodically kept at least 30 per cent above the dosage level of the group so that if a toxic reaction occurs we have only one patient who requires 24 hour care from the medical staff. The first group of five is started on the new drug only after the pioneer patient has been on increasing doses for a period of one or two weeks. The new group is then started at the same small dose used in the pioneer patient. The dosage for the pioneer is increased until a therapeutic effect is found or a toxic effect occurs as shown by blood counts, urinalysis, liver and kidney function tests, or clinical examination.

Since all present therapies of schizophrenia are dangerous with a morbidity rate of around 1 in 200 patients treated, the initial study must aggregate almost 600 patients before the toxicity peculiar to a new chlorpromazine congenor can be determined. Obviously, the pharmaceutical industry will not wait for one investigative team to amass 600 clinical trials so the rivalry of the several investigators results in premature publication of individual findings on insignificant numbers of patients. Because of the small equity of each group, the various investigative teams rapidly lose control of the situation, and the supplier of the new drug may decide to hold a press conference to advise the public about the great new drug, at the same time advising the physician by airmail that clinical supplies are presently inadequate, but will be adequate by the time a condensation of the press conference appears in digest form in a monthly magazine.

DOUBLE-BLIND TEST PROCEDURE

Are we justified in using any of the present therapies of schizophrenia under double-blind test conditions? We have available only toxic drugs, which must be given to the tolerance of the individual patients in order to get the maximum therapeutic effect. I personally would not be happy as the unenlightened ward physician if a double-blind test were in progress on my ward with either reserpine or CPZ.

[1]Cooperative to the extent of taking medicine, providing urine samples, and allowing blood samples to be taken.

(Neither of these drugs would fool a ward physician for more than two days.) However, the psychiatric evaluation team could be uninformed as to therapy and might not guess the nature of the drugs for several weeks if the peripheral symptoms of reserpine therapy were prevented with atropine methylnitrate.

Dr. Harris Isbell has pioneered in human investigation, yet in his published reports the dangerous studies such as morphine, alcohol and barbiturate addiction are not on a double-blind test basis, while his studies on frenquel *versus* LSD-25 and minimal doses of barbiturates needed to produce a withdrawal syndrome were doubly blind. The experience of this able investigator with dangerous drugs should guide us in our present recommendation.

COMPLEX DESIGN REQUIRED

As stated before, the testing of reserpine, CPZ, and placebo under the names of alphaline, betaline and gammaline would not have the ward physician or the psychiatric evaluation team guessing very long. The addition of 50 per cent reserpine and 50 per cent CPZ under the name of deltaline might help, and the addition of a drug placebo such as neostigmine under the name of epsiline might be further efficacious. (Names should be used rather than numbers to prevent confusion of the nursing staff and to reassure the patient and the relatives that therapy has at least been tried enough to have a name and not a number.)

However, the complexity of the experiment greatly increases the size of the medical team needed to compare in a statistically valid manner the effect of various therapies. Thus, one team supervising treatment of 60 patients should aggregate only 10 patients per group if six different types of therapy were employed simultaneously. Therapy with reserpine must be continuous for three months so that each group would have only 20 male and 20 female patients at the end of one year of therapy.

Patients chosen for the experiment should be somewhat remissible with ECT to avoid inclusion of those hospitalized patients who do not respond to any therapy. The patients should be further assayed prior to treatment with 30 per cent CO_2, amobarbital, dibenamine, methacholine and epinephrine to determine any correlation between these rapid tests and ultimate remission under ataractic drugs. In addition, biochemical tests such as urinary 5-hydroxy indole acetic acid (Brodie), insulin tolerance tests (Meduna), uropepsinogen (Mirsky), aberrant amine excretion (Weber, and Honegger and Rieder), diazotizable urinary excretion products (McGeer, et al.), specific gravity of spinal fluid (Sherwood), and numerous others should be done.

At present, the active investigator in the study of the schizophrenias is plagued with more mundane problems than the double-blind test. Some of these are: (1) How can the investigator be certain that the patient has received his daily dose of drug? (2) How does one recruit capable, stable medical and capable nursing, psychological and laboratory personnel? (3) How does one get urine samples from untidy patients or blood samples from uncooperative patients? (4) If a patient in a control or treated group needs specific sedation or hydrotherapy, should every patient receive the same therapy? The personnel problems would be solved if an adequately financed center for the study of schizophrenia were established at each medical center.

The disadvantages of premature publication might be ameliorated if the pharmaceutical industry would agree to give a single investigative team exclusive rights for a period of one year[a] to study a new ataractic drug. This concentration of effort would have some disadvantages but many more advantages in that the team could be more adequately financed and the question of the use of the investigator's data for premature publicity purposes would be more firmly controlled.—CARL C. PFEIFFER, M.D.

[a]This option should be subject to review at quarterly periods to ascertain the interest of both parties in the continued trial of the specific drug under test.

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At the same time a host of new uses has been found for by-products which yesterday were considered waste material. More than 200 profitable products are now produced from the corn plant. Today in the great corn belt more than 90 per cent of the corn is hybrid and the yield per acre 200 per cent more than it was at the turn of the century.

Great advances have, in like manner, been made in the production of all basic grain crops. The same is true of the entire list of vegetables and fruits, many varieties of which have been developed for special uses. This applies to apples, strawberries, melons, potatoes, peas and other products. Some apples are especially flavorful and good for use as fresh fruit, but are not satisfactory for canning or freezing. Only one or two varieties of sweet peas are suitable for freezing —while many varieties of both sweet and early June peas are excellent canners.

Livestock production has undergone tremendous changes. Beef cattle in the Hereford, Angus and Short Horn breeds have been highly developed. These breeds do not thrive in hot or tick infested areas. There is one breed, the Brahman from India, that is immune to ticks and which thrives in hear. The cross breeding of the Brahman with the Short Horn has developed a new type called Santa Gertrudis, and a similar development with the Hereford breed is well under way. These cross breeds are immune to ticks and will thrive in the year-round grazing areas of the South. Cheap feed in the form of citrus pulp is also available in the Southeast.

Developments in animal feeds and feeding have been remarkable. Practically all feeding is now on the basis of a perfectly balanced diet with special attention to the quantity and quality of the protein content. One recent development which may very well change the entire economic side of feeding cattle is the use of a chemical called urea, obtained from nitrogen in the air. Combined with ground corn cobs, corn stalks, and other cellulose matter, it provides a satisfactory feed.

Another development of importance was the production of a synthetic milk for little pigs. A little pig has to get its start in life on mother's milk—no other milk will do. It took a lot of research and developmental work to duplicate sow's milk synthetically. The practical value of this development is that it will enable the swine producer to save more pigs per litter—probably cut the losses 50 per cent, and practically eliminate the type of pig commonly known as a "runt." Most of the loss results from the fact that a sow is a clumsy beast and is likely to lie down on and crush some of her babies in the first two days after their birth. Now, with synthetic milk available, a sufficient number of the little pigs can be removed to minimize the crushing hazard, and they can be nipple-fed by a machine especially developed for the purpose. Pigs fed in this manner grow faster and sturdier.

POULTRY THIRD IN VOLUME

Poultry ranks third in the volume of meat used by our people, its consumption rate exceeded only by pork and beef. Here again, we are reaping the benefits of scientific research and developmental work. One of the best things that ever happened to the public feeding industry was the development by the United States Department of Agriculture of the broad-breasted bronze turkey. In most places it is now a year-round item, used for a wide variety of attractive dishes. Any food service establishment using turkey for fewer than 10 different dishes should promptly get a copy of the National Restaurant Association "Turkey Handbook" and carefully study this fine quality, profit making meat item.

A few years ago science entered the field of meat-chicken production. Today we have broiler-chicken production

Col. Logan is director of research, National Restaurant Association. This article is condensed from a paper presented at the COLLEGE AND UNIVERSITY BUSINESS food institute, 1956.

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plants that operate with the precision of any modern factory. This part of the poultry industry has grown into three separate but inseparable industries. First is the hatchery that produces day-old chicks for the farmer, second is the great feed manufacturing section, and third is, of course, the production of the meat chicken. This group is constantly concerned with the development of better meat chickens and ways and means of reducing losses. The farmer now handles 10,000 chickens in one 40 by 250 foot shed where heat, light, automatic feeding and watering, and sanitation are controlled with exactness. At the end of 10 to 11 weeks the entire flock is delivered to a chicken processing plant where, under the most modern conditions, the birds are made ready for market. The farmer produces four flocks per year. The processing plant, by contractual arrangement, staggers production among the farmers so as to receive about an even flow of incoming flocks every week.

ALLIED INDUSTRIES COOPERATE

Allied industries, such as the feed manufacturers, machinery and equipment people, are all integrated into the research work. There are now at least a half dozen areas where broilers are produced in large numbers. This industry has and will continue to have a powerful influence on the national meat economy. Because of the relatively short cycle of production, it is able to level the peaks and fill the valleys in the much longer production cycles of swine and cattle.

The sister industry of the broiler production is, of course, the egg industry. A whole book could be written on the research and developmental work in that field. Suffice it to say that special strains of egg producing hens have been developed; cannibalism, which caused substantial loss of chickens in the past, has been eliminated; culling of flocks is now scientifically done; attention has been given to egg shell thickness—which presents a marketing hazard—and the mechanics of harvesting, grading and storing eggs on the farm have been greatly improved.

Fish and seafoods also have received a big share of scientific attention. A major part of this has been accomplished by industrial organizations with the assistance or under the guidance of the commercial fisheries division of the Fish and Wildlife Service, U.S. Department of the Interior.

Because of the rapid action of surface bacteria, fish stale in a short time even when packed in ice. Temperatures at or below zero are required for good storage. The problem of staling is largely solved by quick freezing the fish as soon as they are taken from the water. But since only a limited amount of fish is marketed in round-dressed form, and the bulk is marketed in filleted or other processed form, the fish frozen at sea must be thawed, processed and then refrozen. This has an adverse effect on texture and flavor. The problem may now be partially solved by the use of an antibiotic dip.

The salt waters of the earth hold a limitless potential in food resources. Scientists can now foresee the possibility of the production of sufficient food for all the people on earth from the single-celled sea growth known as plankton.

These remarkable improvements in production would have only limited value, however, except for equally noteworthy improvements in the science of food preservation. Within this field contributions are steadily being made by physicists, nutritionists, packaging engineers, chemists, food engineers and food technologists, and refrigerating engineers. The objectives are to harvest each product at its most desirable stage of growth and development, to handle it from the instant of harvest to the point of processing by methods designed to cause the least possible loss of color, flavor or nutritive value, and then, with all possible speed, to apply some means of preservation that will prolong its useful life.

CHANGES IN POTATO MARKETING

The handling of potatoes is a good example of applied technology, and great changes are currently taking place in potato marketing as the logical result of that work. It is known that a potato which is heavy in starch and which has a specific gravity of 1.09 or more is almost sure to be a good baker and a good masher, regardless of variety or place of origin. Conversely, one that has a specific gravity of 1.07 or less will seldom be satisfactory for baking and mashing but will be good for salad work. A marketing test on the basis of specific gravity proved that consumers are ready and willing to pay a reasonable premium for potatoes that are best suited for the end product desired.

Nearly all large cities are today being served with commercially peeled potatoes which are chilled and dipped in a weak sulfite solution to delay darkening and discoloration. These potatoes are sold to the public feeding industry in boiler form and cut for deep frying. Within the last three years, potato processors have launched a new type of processed potato. It is cut for deep frying, partially cooked in deep fat, and then frozen. These potatoes are almost ideal for the average restaurant. They are cooked from a solid frozen state to completion in about four minutes, absorb less fat from the kettle, have a splendid color and good texture—and they eliminate a lot of kitchen labor.

SOLVES POTATO PROBLEM

Everyone knows that it is difficult to make good mashed potatoes from new or early crop tubers. Some years ago one or more manufacturers started to produce dehydrated, granulated, late variety potatoes which could instantly be made into mashed form. The product was good but a little too exacting in its reaction to variations in the quantity and temperature of added liquid. After three years of research, the eastern regional laboratory of the Department of Agriculture has produced a dehydrated potato flake which is much more tolerant to temperature variation of the added liquid and which produces splendid mashed potatoes. The first marketing test of this product will be made this year. It is safe to predict that it will solve the potato mashing problem—and will become an item of constant use.

One of the most successful of tests on food preservation by ionizing radiation—atomic energy—was that made on potatoes. Potatoes treated by gamma ray radiation remained in perfect condition without sprouting or deterioration for more than one year. No one can predict just where that test will lead but it is quite probable that sometime in the future practically all sound and unblemished potatoes will be irradiated before marketing. Potatoes are now being canned and, of course, the potato chip industry has grown to a point where it accounts for a substantial percentage of the crop. Thus it is that the king of all vegetable crops is finally coming into the sphere of scientific preservation.

In the field of fresh fruits and vegetables a lot of attention has been given to the control of enzymes by quick

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cooling in the field at the time of harvest, and to types of packaging material that will exclude most of the oxygen without smothering the product. All products are living, breathing things, and the rate of respiration is controlled by temperature—the higher the temperature, the faster the breathing. All of these products contain enzymes which bring about changes in composition and texture. In some instances the enzymatic action changes sugar to starch—as in the case of sweet corn—which is undesirable. We now know that the respiratory rate of sweet corn is 11 times faster at 86° F. (cornfield temperature) than at 40° F. An ear of corn held at 40° F. will be as good at the end of the eleventh day as one held one day at 86° F. This fact has been used in a tremendous marketing program by a large southeastern company.

ELIMINATE STORAGE HAZARD

Apples held for three days after harvest at orchard temperature (around 80° F.) will lose 30 days of storage life. Apples placed in ideal storage temperature continue to breathe and give off a pronounced aroma. This aroma will cause surface deterioration commonly known as "scald." Today this storage hazard is eliminated by drawing the air of an apple storage room through activated carbon.

Head lettuce is no longer processed through a packing plant, crated and iced; it is packed in the field into cardboard cartons, rushed into a huge vacuum machine where the temperature is immediately dropped to below 50° F.—and it is shipped dry in refrigerated cars to market.

One of the outstanding developments which has taken place in the field of canned foods is a new method called "aseptic" canning. Thus far it can be used only for liquids, but the method will undoubtedly be extended to other things later on. This method eliminates the need of heavy and prolonged retort cooking which has to be done in order to make products commercially sterile. The heavy cooking is the reason canned products have a flavor different from fresh products. There are indications that aseptic canning may ultimately be used for the marketing of fresh fluid milk.

The freezing preservation of food became a commercial industry of importance less than 30 years ago. Today it is an important part of the daily life of every American. Its use has brought our orchards and gardens, forests and fields, streams and vineyards into every corner grocery store in the land. It has enabled people in all walks of life to store in their homes for immediate use a variety of foodstuffs which their own fathers could not have obtained for a king's ransom.

At the end of the war, when canned foods were difficult to obtain, several companies started into the business of freezing precooked foods—which were not rationed. The cost was high and in a number of cases the products were not very acceptable. As soon as canned goods became available in abundance, the frozen precooked foods practically disappeared from the market. About six years later in 1952 they began to appear again, and products such as chicken and turkey pot pies, which sold at a reasonable price, were accepted by the public. Since that time precooked frozen foods of almost endless variety have come onto the market, and the volume continues to grow and varieties to increase each year.

In 1955 the production of frozen foods in the United States totaled 7.4 billion pounds, an increase of about 58 per cent over the 1950 production. The major part of this phenomenal growth was due to citrus concentrates and cooked foods, the former increasing from about 400 to 800 million pounds and the latter from practically nothing to 558 million pounds.

OPENS UP NEW FIELDS

Consumer acceptance of frozen cooked foods sold through grocery stores has opened a new and unlimited field to restaurant operators. Since 1950 a number of large restaurants have gone into food freezing on a large scale, selling their products through retail outlets and through their own "carry-out" department.

One current research project of interest in the field of frozen food is that of frozen fried chicken. Everyone is familiar with the black bone condition which follows the freezing of young and tender chickens. This condition is caused by the seepage of blood through the porous bone structure from the bone marrow. This condition in no way affects the quality of the bird but it does have a pronounced effect upon its salability in restaurants. If the bird is cooked before freezing, there is no bone discoloration. The U.S.D.A. western regional laboratory, in its studies on precooked frozen chicken, has found that it has a storage life of approximately six months at 0° F.

Another research project of great significance is that of condensing high quality fluid milk, packaging it in hermetically sealed containers, and marketing it at a temperature just above freezing. An article in the *American Milk Review* recently stated, "The milk industry is on the threshold of the most revolutionary change in its history." Marketing tests of this product were made in San Francisco and Los Angeles. In San Francisco, where the consumer saved three cents per quart, it was found that one-quarter of all the milk sold was in concentrated form. The results were practically the same in Los Angeles. The point of greatest significance in this new method of fluid milk handling is that concentrates can be produced in the surplus milk producing areas and shipped into deficit areas. But there are many other problems to be solved before this development can be put into national distribution.

FREEZE BAKED GOODS

Within the past few years the bakers of the country have solved the five-day-a-week labor problem by freezing bakery products in sufficient quantity during the five-day production to provide seven days of sale. Recently one manufacturer has developed a continuous freezer capable of handling a variety of baked goods at high speed. With this equipment, for example, a full week's production of whole wheat bread might be baked in one morning, and the portion not needed for immediate sale could be frozen for orders during the coming week.

Perhaps one of the most interesting of recent research projects is that of combining irradiation with refrigeration in the preservation of meat. Research on this work now goes on at Oregon State College and the University of Illinois. It is believed that a mild degree of irradiation followed by a proper refrigeration program will afford preservation without introducing the off-flavors in meat, which have previously been found in all highly irradiated meat products.

Another form of food preservation is dehydration. The item which is probably of greatest importance to restaurants at this time is the new type of dried milk solids which dissolve instantly in water. Millions of pounds of green peppers, celery and other seasoning vegetables are dehydrated

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each year for the manufacturers of dried soup mixtures and other products. Precooked dehydrated rice is sold extensively on the retail market. Many of the "ready-to-mix" cake, muffin and cookie mixes contain high quality dehydrated whole eggs or egg whites. This new type of dehydrated egg is destined to become a product of great importance to the public food service industry. Dehydrated bases for soups and gravies are becoming plentiful. Each of these dehydrated products is much better than it was at the end of World War II. Each is being worked on constantly for further improvement. Perhaps the outstanding example is the soluble coffee of today compared with that of 1945. With the continued improvement which will surely be made, soluble coffee will be the principal form in which future crops will be marketed.

Halfway between freezing and dehydration is a new type of preservation called dehydrofreezing. In this process the product is partially dehydrated and then frozen. Apples, dates and cherries are now being marketed in this form. One company soon will start dehydrofreezing peas.

During recent years, great attention has been given to chemicals in food preservation. Antioxidants are in use in animal and vegetable fats which have practically removed these products from the "perishable" food list. Citric and ascorbic acids are used in certain foods to preserve color and prevent browning. Monosodium glutamate is added to enhance flavor. Carageenen (Irish moss) is being used as a stabilizer. Papain is being used to tenderize meat and poultry. The latest addition to the list is the antibiotic aureomycin. Poultry and fish dipped in water containing this antibiotic have a substantially prolonged marketing life. Tests are now being made of the effect of other antibiotics on vegetable products. Emulsifiers, dessicants, humicants, wetting agents, colors and aromatics are in use. This particular field seems limitless.

What do all these advances in food production and processing mean to the public food service industry? They mean that most of the preparation prior to cooking food will be on a mass production basis in modern factories close to producing areas, that there will be fewer employes in restaurant kitchens, and a doubling in per-man-hour production rate with less physical effort and more pay for the needed skilled help. They mean the availability of a great variety of products, ready for immediate use, continuously uniform in quality, and protected against deterioration. These packaged foodstuffs will afford perfect inventory and portion control and remove all guesswork from menu pricing. These scientific advances provide an administrative and operational tool which will help solve the serious problem of the advancing cost of labor and move the food service industry into a position where its production efficiency will approach that of other great manufacturing industries, such as the automotive, aircraft, textile and rubber.

How about the future? What does it hold? Undoubtedly there will be great forward strides in knowledge of human nutrition, particularly in the building of sound bodies in the young and adolescent, in the elimination of deficiency diseases, and in the dietary of the aged. And much of this will be translated into plant culture and protein production. There are on this continent about 15,000 species of plant life. Only about 200 are cultivated and less than a dozen account for the bulk of current production. Science, through research, will extend this to hundreds of plants. Crops will be produced on presently barren soil, and profitable uses made of material now classified as waste. New foodstuffs, not yet visualized, will become available for human welfare.

The subject of heat transfer will come in for accelerated research. Just now we begin to see the use of microwave and infra-red cookery, and are testing the possibilities of gamma rays for food preservation. Many great developments will come from these and other spectrums in the broad field of electro-magnetic energy. Ultrasonics—high frequency sound waves—will play an important rôle in future food preservation. Chemicals, enzymes and antibiotics will constantly increase in use in all phases of food production and processing.

We are living in a revolutionary period with scientific developments rapidly changing our concept of values and our mode of life. Each of us, willingly or not, is participating in the change. Consideration and proper use of these advances definitely must be made part of the thinking of anyone who aspires to business success today or tomorrow.

Menus for April 1957

Essie B. Schneider
Dietitian
Salem Memorial Hospital
Salem, Ore.

1 Orange, Grapefruit Soft Cooked Egg, Bacon • Beef Soup Roast Beef, Gravy Steamed Potato Green Beans With Bacon Lettuce, Tomato Salad Hot Rolls Apricot Upside Down Cake • Cream of Celery Soup Meat Loaf With Gravy Buttered Peas Deviled Egg Salad Celery Sticks Pineapple Rice Fluff	**2** Prunes Scrambled Eggs, Bacon • Broth With Noodles Liver and Bacon Mashed Potatoes Buttered Carrots Fruit Salad, Whipped Cream Apple Pie With Cheese • Mushroom Soup Chicken Wings Buttered Squash Lettuce Wedge, French Dressing Peaches	**3** Half Grapefruit Poached Egg, Ham • Split Pea Soup Pork Chops Mashed Potatoes Spinach With Bacon Vegetable Salad Strawberry Shortcake • Potato Soup Creamed Chipped Beef on Toast Asparagus Crushed Pineapple, Cream Cheese in Lime Gelatin Lemon Sherbet	**4** Banana With Cream Fried Egg, Bacon • Fresh Vegetable Soup Turkey With Dressing Gravy Mashed Potatoes Buttered Peas Waldorf Salad Ice Cream • Cream of Chicken Soup Baked Ham Candied Sweet Potatoes Buttered Corn Lettuce, Tomato Salad Fruit Gelatin, Whipped Cream	**5** Peaches Poached Eggs • Clam Chowder Salmon With Lemon Escalloped Potatoes Harvard Beets Vegetable Salad Corn Meal Muffins Coconut Cream Pie • Tomato Soup Baked Macaroni, Cheese Asparagus Pickled Beets, Carrot Sticks, Ripe Olives Ice Cream, Cookies	**6** Stewed Prunes Scrambled Egg, Bacon • Beef Soup Creamed Chicken on Hot Biscuits Mashed Potatoes Lima Beans Orange, Coconut Salad Peaches • Broth With Rice Roast Beef, Gravy Potatoes Cooked With Roast Buttered Peas Perfection Salad Loaf Cake
7 Applesauce Poached Egg, Sausage • Broth With Rice, Tomato Baked Ham With Crushed Pineapple Mashed Potatoes Wax Beans Lettuce, French Dressing Apricots • Tomato Soup Meat Balls in Gravy Broccoli Stuffed Celery, Olives, Pickles Cake	**8** Banana With Cream Fried Egg, Bacon • Beef Soup Roast Beef, Gravy Steamed Potato Spinach With Bacon Lettuce, Tomato Salad Hot Rolls Chocolate Pudding • Cream of Pea Soup Cold Ham, Potato Salad Celery Hearts, Olives Apple Pie	**9** Stewed Prunes Scrambled Eggs, Bacon • Fresh Vegetable Soup Meat Pie Steamed Potato Buttered Beets Pineapple, Grated Cheese Salad Cherry Cobbler, Cream • Cream of Mushroom Soup Steak Baked Stuffed Potato Buttered Celery Vegetable Salad Custard	**10** Rhubarb Fried Egg, Fried Ham • Broth With Barley Veal Roast Mashed Potatoes Brussels Sprouts Fruit Salad, Whipped Cream Dressing Cherries • Cream of Tomato Soup Cold Roast Pork Deviled Egg, Potato Chips, Celery Hearts Icebox Salad Apple Pie With Cheese	**11** Canned Grapefruit Poached Egg, Bacon • Chicken Noodle Soup Liver and Bacon Steamed Potato Spinach With Lemon Lettuce, Tomato Salad Cream Puff, Chocolate Sauce • Cream of Asparagus Soup Spaghetti, Meat Balls Buttered Peas Pickled Beets, Carrot Sticks Ice Cream	**12** Applesauce Soft Cooked Eggs • Oyster Soup Halibut With Lemon Browned Potatoes Green Beans Vegetable Salad Ice Cream, Cookies • Cream of Mushroom Soup Macaroni and Cheese Lima Beans Tomato Aspic Salad Lemon Pie
13 Half Grapefruit Soft Cooked Egg, Bacon • Beef Soup Fried Ham Mashed Potatoes Spinach With Bacon Waldorf Salad Chocolate Pudding, Cream • Cream of Celery Soup Baked Turkey, Noodles Baked Potato Half Asparagus Banana, Pineapple Salad Gelatin, Whipped Cream	**14** Applesauce Scrambled Eggs, Bacon • Broth With Rice, Tomato Chicken, Homemade Noodles Buttered Corn Lettuce Wedge, French Dressing Marshmallow Roll • Cream of Chicken Soup Steak Buttered Peas Celery Sticks, Pickled Beets Peaches, Cookies	**15** Stewed Prunes Poached Egg, Bacon • Broth With Barley Meat Pie With Biscuits Tomatoes Spinach With Bacon Fruit Salad, Whipped Cream Dressing Cherry Cobbler, Cream • Tomato Soup Hot Roast Beef Sandwich Carrots Cooked With Roast Vegetable Salad Pineapple Rice Fluff	**16** Banana With Cream Scrambled Eggs, Bacon • Fresh Vegetable Soup Steak Mashed Potatoes Buttered Beets Pear With Grated Cheese Salad Apple Pie With Cheese • Cream of Asparagus Soup Cold Ham, Potato Salad Lettuce Wedge, 1000 Island Dressing Ice Cream	**17** Apricots Poached Egg, Sausage • Broth With Noodles Pork Chops Steamed Potato Creamed Carrots Orange, Coconut Salad Strawberry Shortcake • Potato Soup Creamed Chipped Beef on Toast Green Beans Lettuce, Tomato Salad Spice Cake	**18** Applesauce Fried Egg, Bacon • Chicken Noodle Soup Meat Loaf With Gravy Mashed Potatoes Buttered Peas Lettuce Wedge, French Dressing Bread Pudding, Cream • Broth With Rice Roast Turkey, Dressing Gravy Asparagus Waldorf Salad With Dates Celery Sticks Royal Ann Cherries
19 Canned Grapefruit Scrambled Eggs • Clam Chowder Salmon With Lemon Escalloped Potatoes Buttered Carrots Lettuce, Tomato Salad Bran Muffins Cherry Cobbler • Tomato Soup Creamed Tuna on Toast Buttered Corn Vegetable Salad Pears	**20** Banana With Cream Soft Cooked Egg, Bacon • Beef Soup Liver and Bacon Oven-Browned Potato Harvard Beets Waldorf Salad Pineapple Chunks • Cream of Pea Soup Chicken Salad Asparagus Pickled Beets, Stuffed Celery Princess Pudding With Custard Sauce	**21** Applesauce Fried Egg, Bacon • Fresh Vegetable Soup Roast Veal, Dressing Gravy Steamed Potato Green Beans With Bacon Fruit Cup Ice Cream, Cookies • Cream of Mushroom Soup Cold Baked Ham Potato Salad Pickled Beets, Celery, Carrot Sticks Marshmallow Roll	**22** Grapefruit, Orange Poached Egg, Fried Ham • Beef Soup Steak Baked Squash, Marshmallows Mashed Potatoes Sliced Orange Salad Hot Rolls Rice Pudding, Cream • Tomato Soup Meat Loaf, Mushroom Sauce Buttered Corn Waldorf Salad, Dates Coconut Cream Pie	**23** Stewed Prunes Scrambled Eggs, Bacon • Broth With Noodles Roast Beef, Gravy Steamed Potato Whole Carrots Cooked With Roast Lettuce Wedge, French Dressing Apricot Upside Down Cake • Potato Soup Chicken Pie Buttered Peas Vegetable Salad Ice Cream, Cookies	**24** Banana With Cream Soft Cooked Egg, Sausage • Split Pea Soup Steak Mashed Potatoes Broccoli Fruit Salad, Whipped Cream Dressing Strawberry Shortcake • Fresh Vegetable Soup Cold Pork, Deviled Egg Asparagus Sliced Tomato, Pickled Beets, Celery, Olives Apple Pie With Cheese
25 Stewed Prunes Soft Cooked Egg, Bacon • Beef Soup Breaded Pork Chops Mashed Potatoes Cauliflower Waldorf Salad Jelly Roll • Cream of Pea Soup Braised Short Ribs With Vegetables Baked Potato Ice Box Salad Baked Apple With Cream	**26** Fresh Applesauce Poached Eggs • Cream of Mushroom Soup Salmon, Tartare Sauce Escalloped Potatoes Buttered Peas Grapefruit Salad Corn Bread Cream Puff, Chocolate Sauce • Tomato Soup Creamed Tuna on Toast Buttered Squash Deviled Egg, Celery Hearts Ice Cream, Cookies	**27** Banana With Cream Scrambled Egg, Bacon • Broth With Noodles Stew With Vegetables Lettuce, Tomato Salad Bread Pudding • Cream of Celery Soup Veal Chops Asparagus Perfection Salad Pickled Beets Berry Pie	**28** Rhubarb Fried Egg, Bacon • Fresh Vegetable Soup Roast Veal, Dressing Gravy Steamed Potato Buttered Peas Fruit Cup Ice Cream, Cookies • Cream of Asparagus Soup Baked Ham, Potato Salad Sliced Tomato, Olives, Celery Sticks Chocolate Cake	**29** Canned Grapefruit Poached Egg, Bacon • Beef Soup Meat Pie With Biscuit Spinach With Bacon Buttered Corn Fruit Salad, Whipped Cream Cherry Upside Down Cake • Cream of Celery Soup Steak Baked Potato Half Broccoli Lettuce Wedge, French Dressing Ice Cream, Cookies	**30** Apricots Scrambled Eggs, Sausage • Split Pea Soup Roast Beef, Gravy Steamed Potato Brussels Sprouts Vegetable Salad Apple Betty With Cream • Potato Soup Chicken Pie Buttered Carrots Waldorf Salad Rhubarb Pie

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REFLECTIONS ON HOSPITAL LIGHTING

3. LIGHTING NURSES' STATIONS AND LABORATORY

HOWARD HAYNES and K. A. STALEY

PROBABLY the most important paper work in the hospital routine is done at the nurses' stations. Where the stations are at the intersection of corridors, as they so often are, a common solution to the lighting problem is to place one additional corridor light over the main desk. However, a higher degree of excellence in the lighting is justified to satisfy the more exacting eye work done.

Not less than 30 to 50 footcandles on all desks is required first of all. The lighting equipment should be extensive enough to produce this value over the full length of the nurses' station space; therefore, the luminaires, as a rule, should extend well beyond the desk limits. It is also a worth-while addition to place single rows of fluorescent tubes under the counters to light the desk areas. Some caution is necessary in using this type of design to ensure that the reflection of the tubes from glossy surfaces will not be annoying. Soffit lighting from ceiling panels is generally preferred; the images of lamps close to the work may "veil" a large part of the desk area.

The nurses' station is one of the most important places in the hospital from the standpoint of lighting because of the visual work done there. Here, 80 footcandles are supplied on the desk areas; 40 footcandles on other parts of the space, and 60 on the chart rack. The corridors also are very well lighted.

Nurses on post duty have to look up along the corridors as well as down on the records on which they are working. The shifting of attention is significant. If the brightness of the paper is very high and that of the corridor is very low, the contrast may make seeing difficult, although the nurse may not be acutely conscious of the contrast. A tolerable difference of the two brightnesses might be in the ratio of 10 to 1; anything more than this would be classed as uncomfortable. The ratio of the two brightnesses is extremely important in visual comfort. In most corridors it is probably greater at night since no daylighting is present, although bright windows in the field of

This is the third in a series of articles on hospital lighting. The authors are application engineers in General Electric's Nela Park lamp and lighting headquarters in East Cleveland. They have been gathering the material for the last three years. The MODERN HOSPITAL is presenting the articles serially as reference aids to the hospital architect, designer, consulting engineer, administrator or departmental executive who is planning new space or the relighting and redecorating of existing space.

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- **Leaves a lustrous anti-skid protective finish**
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Originators of Power Scrubbing and Polishing Machines

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BRANCHES IN ALL PRINCIPAL CITIES

Above: Lighting under the shelf countertop from 30 watt tubes varies between 30 and 80 footcandles. Two 60 watt lamps supply 50 footcandles.

Above: All surfaces of the cavity and the lattice-louver ceiling are white as are the walls here. General illumination is between 30 and 40 footcandles.

Above: This nurses' station in an isolation ward has its own built-in lighting system. Single-row fluorescent tubes provide about 60 footcandles on the desk. General illumination is supplied by three 60 watt filament lamps in ceiling bowl.

view frequently cause high contrasts, too.

UNDER-CABINET LIGHTING

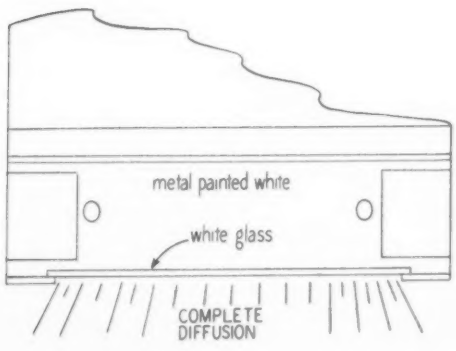
Work space under cabinets is in almost constant use in nurses' stations for preparing charts and reports and for other close eye work. If there is lighting at all under the cabinets, it is usually from bare-lamp fluorescent strips or strips with small reflectors, as previously mentioned. This is one lighting hazard that is easily recognized, but often neglected.

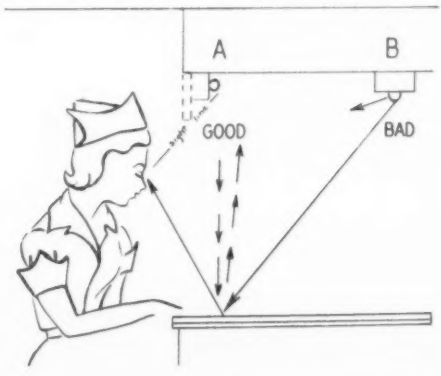
The lighting factors that are important in such work spaces are: (1) orienting of the eye, the work and the light for minimum direct and reflected glare; (2) selecting a low-brightness source or diffusing the source in the luminaire so that a soft light is produced; (3) using sufficient lamps to give a high footcandle level; (4) illuminating the surface reasonably uniformly; (5) painting background and adjacent surfaces in light tones where it is desirable to have the light reflect strongly or to reduce contrast, and (6) using de luxe fluorescent lamps for good color rendition.

ORIENTATION

Persons who work facing a bright window or any other light source for an extended period are ordinarily uncomfortable. If they can face so that the source is at one side, preferably the left (for right-handed people), they are considerably more comfortable. Such orientation is more satisfactory because the reflected glare would be virtually eliminated or minimized. A design of a series of desk spaces with nurses facing at right angles to the cabinets is suggested for a nurses' station.

As a rule, a large source of brightness is more disconcerting than a small one of the same brightness, other





Left: Sketch of proper lighting for work space under cabinet. Soft light is produced by diffusing the source. Right: Good and bad lighting of nurses' station.

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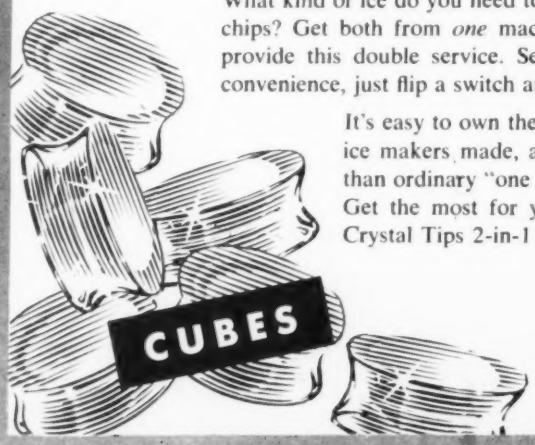

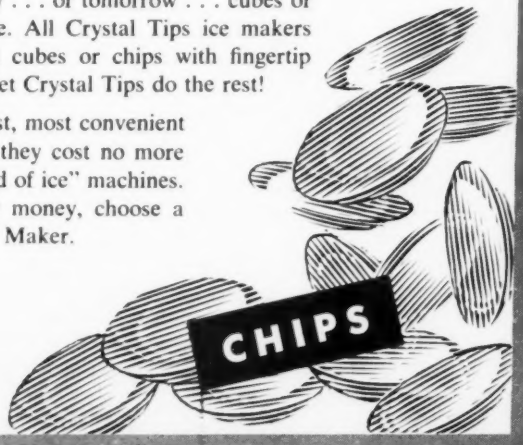

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MODEL B-200-B — Convenient under-counter design; 24 hour capacity storage bin. Produces up to 175 lbs. of cubes or chips per day.

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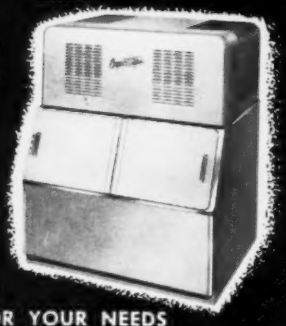

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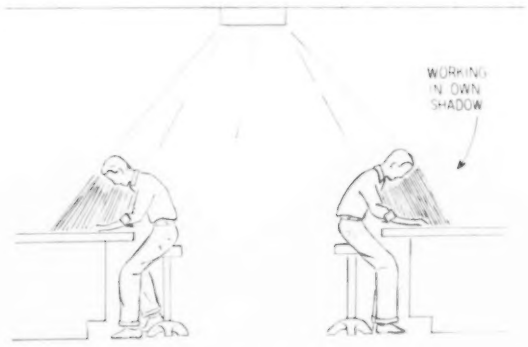
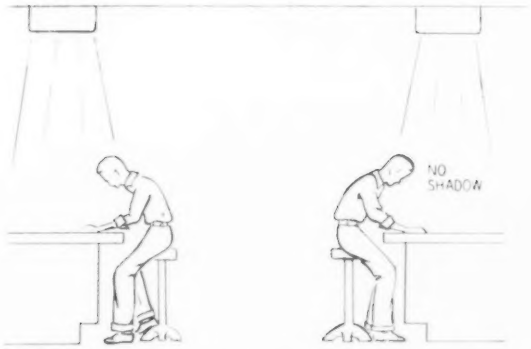


A common error in designing the lighting for laboratories with work spaces on two walls is to place luminaire in center of ceiling so that worker is in his own light.



The principal seeing areas are located against walls and fluorescent luminaires above are in a rectangular pattern. Technician can stand or sit and have shadow-free light.

things being equal. The principle is that a large source directed toward the eye covers a larger part of the retina and its deleterious effect is about in the ratio of the two bright areas, although not exactly so.

LOW-BRIGHTNESS SOURCE

By employing low-brightness fluorescent lamps under cabinets, both the direct and reflected glare are reduced. The 40 watt T-17 lamp (2⅛ inches in diameter) has a brightness of about half that of the conventional 40 watt T-12 lamp (1½ inches thick). The lamps produce about the same lumens. De luxe cool white lamps, when operated at 200 ma., are classed as low-brightness sources also. (Lamps in any installation should be specified as to color and the installation checked to make sure the specified color is in.)

SUFFICIENT LIGHT

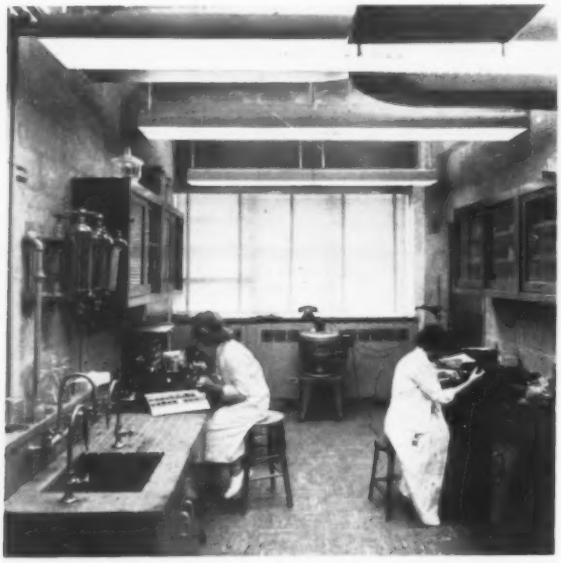
For close eye work, a range between 30 and 50 footcandles is the minimum suggested for desk work. This may consist of a combination of general lighting from the ceiling system plus local lighting. When the local lighting is underneath the cabinets, its value may be considerably lessened (as suggested) by glare—direct from the tubes or reflected from glossy surfaces, such as the plastic shields on record forms.

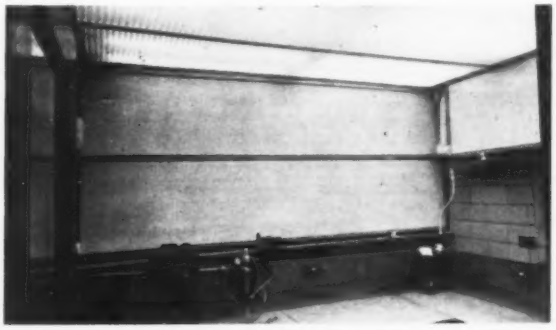
These mirror the tubes and the brightness is quite disturbing. A nurse may have to hold the forms at awkward angles to see to read names and other data. *The footcandle level is not always a true measure of lighting quality.* It is actually possible that more light in this form may mean more glare and lessened ability to see.

UNIFORM ILLUMINATION

It is virtually impossible to light working surfaces under cabinets to uniform values by use of conventional strip lighting. Positioning the fluorescent strip has much to do with the location of the reflection of the tube on reading matter or records. As shown in the sketch on page 124, the strip in position "B" is located in such a way that the angles involved cause much more reflected glare on books or records than if the strip is at "A."

Another design, which can be built into the cabinets, is still more acceptable. The technic in this is to build in two rows of lamps above diffusing glass or a lens plate. Lamps could be serviced by making the glass removable from below or the whole device could be hinged and thus serviced from inside the cupboard. The heat from



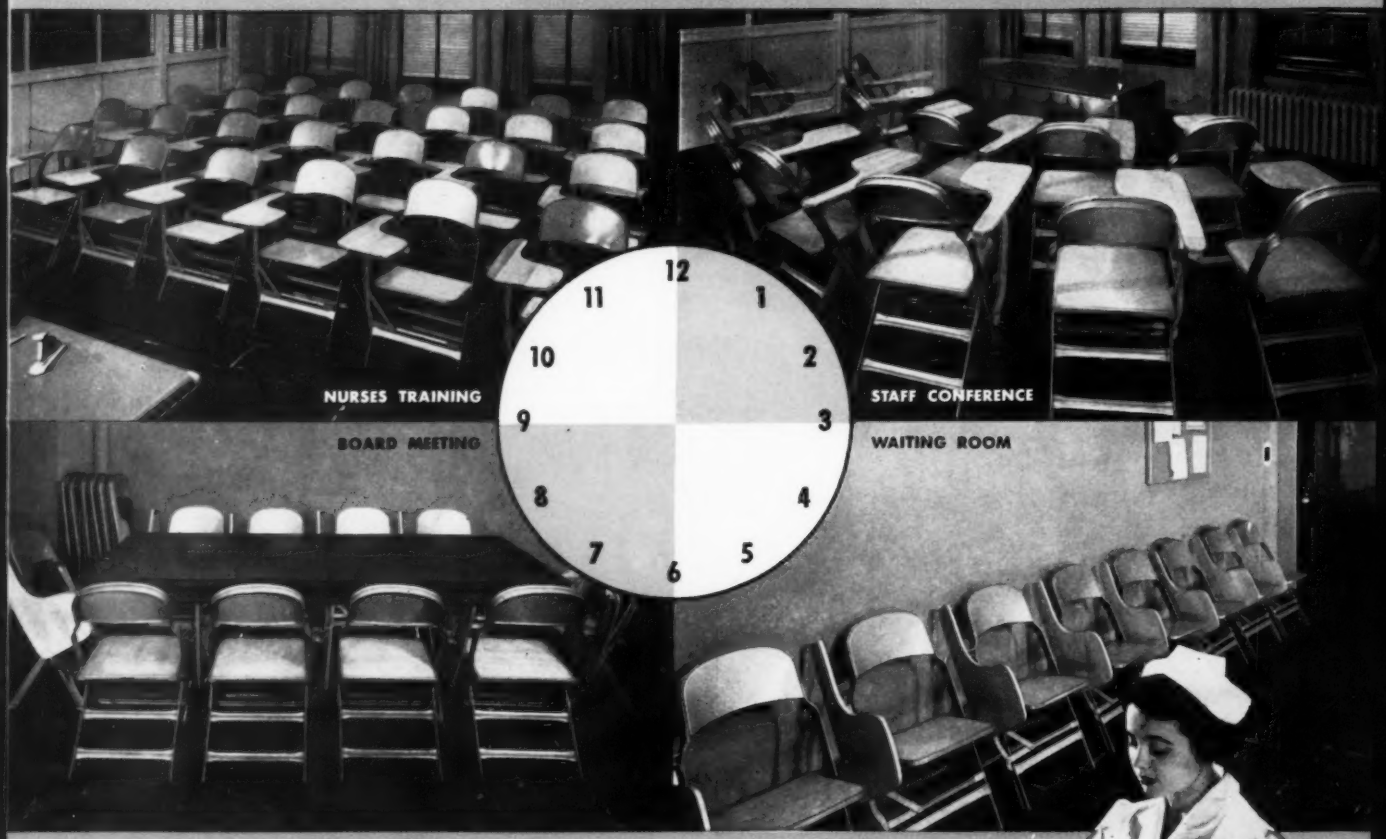


Above: About 65 footcandles of illumination are supplied in this serum center laboratory. The ceiling is completely luminous and represents a type of lighting system that is becoming more extensively used. Conventional fluorescent cool white light-strips are placed above the ceiling.

Left: The rows of twin-tube fluorescent luminaires in this laboratory are on 5 foot centers. More than 40 footcandles of light are provided. The walls and floors are light gray.

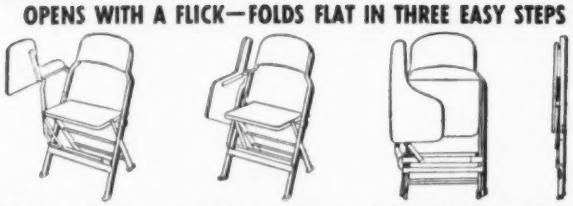
CLARIN *FOLDING* TABLET ARM CHAIRS

EASILY CONVERT ANY ROOM INTO A MULTIPURPOSE AREA IN MINUTES



CLARIN Folding Tablet Arm Chairs help solve the problem of overcrowded hospitals! This exclusive, patented chair is actually a chair and a desk in one. In minutes, a single room like the one pictured can be arranged for nurses training classes, staff conferences, board meetings or to serve as a waiting or out patient room. The tablet arm is scientifically positioned for perfect writing height. When the arm is folded alongside, the chair may be used for any normal seating requirement. Only a minimum storage space is needed as the CLARIN Tablet Arm Chair folds to a thickness of just 3 inches.

OPENS WITH A FLICK—FOLDS FLAT IN THREE EASY STEPS



1. Tablet arm lifts to right, making it easy to get in or out of chair.
2. Tablet arm swings down permitting use as regular chair.
3. Chair folds in normal way and tablet arm swings over flat against it. Folds to 3 inches thick.

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the lamps may be a design consideration. Hence, the use of bare-lamp strips in either position "A" or "B" is not recommended. A person of short stature could readily see the lamp directly while working in front of it. The glare could be most annoying. Wherever such strips are installed, a board should shield the lamps, as indicated at the front surface (dotted).

BACKGROUND, ADJACENT SURFACES

Background surfaces, such as the wall behind and below work surfaces should be light in tone, dull in finish. Semigloss finishes do not depreciate faster than gloss finishes, contrary to popular belief. As a general rule, in this and other "work-eye-light" orientations, the endeavor is to have the light principally on the work, not on the face of the person working. The exception is in lighting the face of a person standing before a mirror. Here the person's face is the "work area," and the problems of eye-work-light orientation are altogether different.

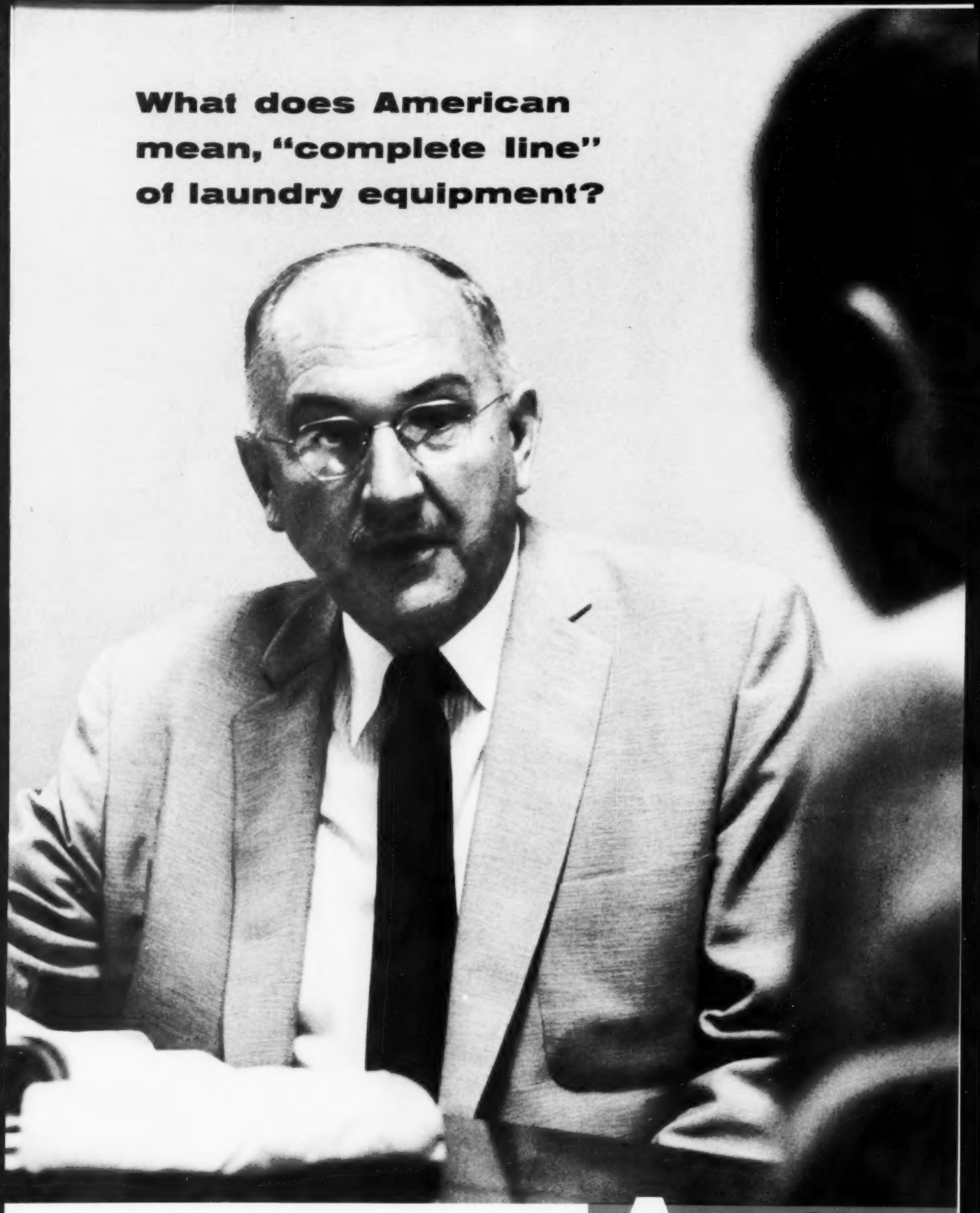
LABORATORIES

Proper orientation of the light and the person using it is violated oftenest in small workrooms, such as laboratories. The location of the benches in a laboratory—large or small—should determine the location of the lighting equipment. As shown, the principal seeing areas are located against the walls and the fluorescent luminaires above them are accordingly in a rectangular pattern. The center lines of the luminaires are over the outside edges of the benches. The location makes it possible for a technician to stand or sit anywhere and have excellent shadow-free light.

In a number of small laboratories with work spaces on two walls, it has been observed that a common error is to locate a fluorescent luminaire in the center of the ceiling. In such a situation the technician is forced to work in his own shadow. Two luminaires, as seen in the sketch, would correct the difficulty. Here, again, is an error in "the eye-the-work-the-light" spatial relationships; it is dreadfully common.

The ultra-modern exception is the laboratory with a completely luminous ceiling, as shown in the photograph. In this room, the shadow hazard is completely eliminated. The only possible criticism of the space is that there is no accent light. However, this may not be significant if portable lights are used for the microscopes.

What does American mean, "complete line" of laundry equipment?



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THE AMERICAN LAUNDRY MACHINERY COMPANY

In washers alone, American offers you 17 different types in 79 sizes

Tumblers, 11 types; extractors, 9; presses, 12; also in various sizes! In all kinds of laundry, dry cleaning and rug cleaning equipment, American offers you a wide range of types and sizes.

This means important advantages for you. There is a complete selection from which to choose *exactly* the equipment you need. One source for all your machinery. One responsibility for its continuing fine performance.

This also means that whatever the size of your plant or your type of work, you'll find American has the right machine for you. A quality machine as well. American is a specialist in designing and building machinery for laundries of all types, dry cleaners and rug cleaners.

Listed below are some examples of this complete line of equipment. Individually, and all together, they show another way you can expect more from American.

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R. H. P. Cascade Washers
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Cyclamatic Washer Control
Rinsomatic Washer Control
Selectro Washer Control
Sentrex Washer Control
Monex Extractors
Motex Extractor
Notrux Extractors
Aircraft Drying Tumblers
High-Speed Drying Tumblers
Zone-Air Drying Tumblers
Challenge Drying & Conditioning Tumblers
Rotaire Conditioning Tumblers
Retron Flatwork Ironers
Streamline Flatwork Ironers
Super-Sylon Flatwork Ironers
Sager Flatwork Spreaders
Foldmaster Flatwork Folders
Stackrite Flatwork Stacker
Trumatic Flatwork Folders
Formatic Coat Unit
Formatic Shirt Unit
Super-Zarmo Presses
Super-Zarmoette Presses

Buckeye Dry Cleaning Washers
Synclor Single-Bath Perchlorethylene Solvent Dry Cleaning Units
Truclor 2-Bath Perchlorethylene Solvent Dry Cleaning Units
Trucleen 2-Bath Petroleum Solvent Dry Cleaning Units
Noex 140° Flash Petroleum Solvent Dry Cleaning Units
Perclor-Saver Tumblers
Zone-Air Dry Cleaning Tumblers
American-Olson Tubular Filters
Aceco Dry Cleaning Presses

Cleveland-American Rug Dusters
Deluxe Mirza Rug Cleansing Machine
Super-Mirza Rug Cleansing Machine
American Pressurized Rug Cleansing Units
Deluxe Mirza Rug Wringer
Cleveland-American Rug Wringers
Cleveland-American Tape Conveyor Tables
Cleveland-American Rug Sizing Roll
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Super-Mirza Rug Dryroom Conveyor

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$$\frac{\text{PAINT} + \text{LABOR}}{\text{AREA}} \div \text{YEARS OF SERVICE} = \underline{\text{TRUE}}\ \text{PAINT COST}$$

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State Hospital Laundries Are Big Business

Increased numbers of patients and decreased use of patient labor in mental hospitals have resulted in expanding and mechanizing the laundries and also in improved operating standards and cost controls

RICHARD SPERLING

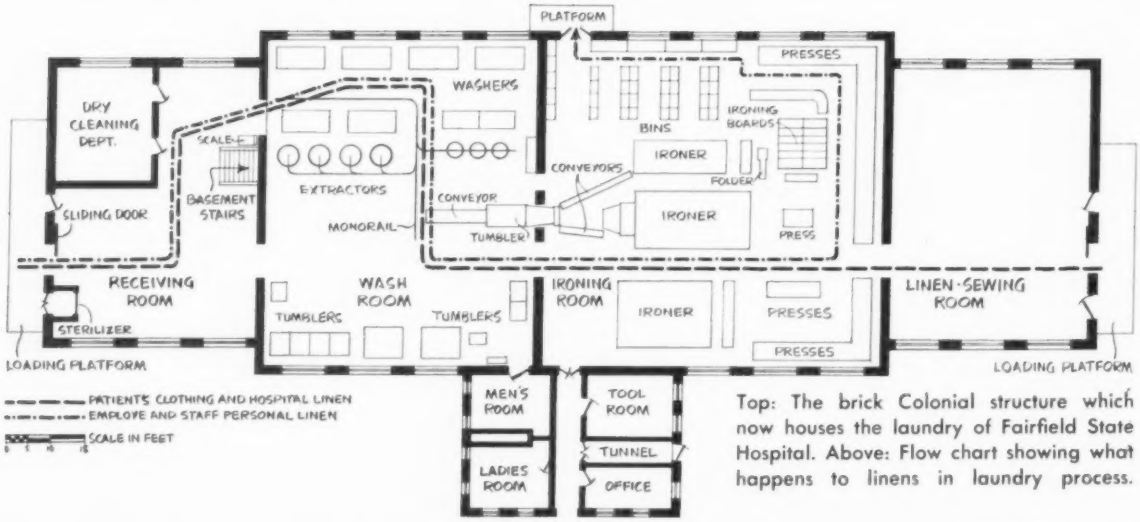
IN THE past, little attention was paid to the appearance and condition of laundry equipment in state mental hospitals. Manual labor was used to process the linen required. Automatic equipment and conveyors were unheard of.

There always was a plentiful supply of patient help to load and unload wash wheels and tumblers, to shake out and fold linen for the flatwork ironers, and to transport this work throughout the laundry. Modern methods of treating mental patients have virtually eliminated this supply of patients, however. The younger, stronger patients who could perform the work required by a nonmechanized laundry no longer remain in mental hospitals, as a general rule, long enough to be enlisted. The long-term patients now are the aged.

This does not mean that the number of patients has decreased. Rather, the increase in demand for beds in mental hospitals has been steady and insistent. This is because of the increasing life span of our people and the advances made in medical science over acute bacterial infections.

These advances that increase the longevity of our people have a direct bearing on all mental institutions. Many states do not have enough facilities to care for the aged and senile who are not mentally ill but merely too old to care for themselves. Not only has the patient census increased, but linen pounds per patient day have increased as a result of better nursing

Mr. Sperling is laundry manager at Fairfield State Hospital, Newtown, Conn.



Top: The brick Colonial structure which now houses the laundry of Fairfield State Hospital. Above: Flow chart showing what happens to linens in laundry process.

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But the truly exclusive feature of the American M. E. is the integrity of design and manufacture which is summed up in the phrase "made by American Sterilizer." Only from that priceless ingredient can you derive the ultimate in convenience, efficiency and lasting economy.

Features

- ★ M. E. construction . . . Monel End Ring welded to nickel clad interior for complete armor against rust or corrosion.
- ★ Improved external appearance — easier to keep clean.
- ★ Improved door hinge simplifies closing.
- ★ Cyclomatic control assures correct sterilization cycle with minimum operator time and attention.
- ★ Vacuum drying keeps work area cooler and drier.
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BULLETIN C-105

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Linen is placed on an 11 foot conveyor that carries it to a sheet spreader. The operators can feed 600 sheets per hour automatically through an ironer and folder.

Small pieces, such as hand towels and pillow slips, are fed through a six-roll ironer equipped with stacking attachment and then through a folder which also stacks.

care and the higher standard of service to the patient.

In order to keep pace with the change in psychiatric policy and advances made in the treatment of the mentally ill, laundering facilities had to be expanded to fulfill the laundering needs at Fairfield State Hospital, Newtown, Conn.

For example, the laundry here not only serves our own hospital, we also do the laundering for Laurel Heights Sanatorium in near-by Shelton, Conn., a 400 bed TB institution. To serve this hospital, our truck makes two pickups and deliveries a week.

Our laundry is located in a brick Colonial building of the same architecture as the rest of the institution buildings. The laundry is 245 by 75 feet, with loading platforms at each end of the building. Soiled linen comes in at one end of the building and clean linen is shipped out the other end, in a completely assembled, streamlined operation. The building is divided into four sections—receiving room, wash room, ironing room, and linen room.

In the receiving room is a large disinfector, blanket and curtain drier, and a separate dry cleaning department. Soiled linen is picked up by a large canvas-covered truck and brought to the receiving room where it is sorted, classified, put in rubber-tired baskets and trucks, and weighed on a platform scale equipped with an automatic printweight device which gives the net weight of linen in each basket or truck.

Linen is then sent to the wash room to be washed and extracted. All tumble work is dry-tumbled, folded and packed for delivery to our central linen room for distribution throughout the hospital. All flatwork, after being extracted, is passed through a preconditioning tumbler that partially dries and removes extractor wrinkles from linen. This linen then can be fed through ironers at a higher rate of speed. When the linen passes through the preconditioner, it is placed on an 11 foot conveyor that carries it to a sheet spreader. Operators on the ironers can feed these sheets automatically through an ironer and folder at the rate of 600 sheets per hour. Linen is then packed in baskets for delivery to the central linen room.

Small pieces such as hand towels, dish towels, and pillow slips, after being preconditioned, are fed through a six-roll ironer equipped with a stacking attachment. The linen is then fed through a folder which also stacks and counts the pieces. This linen also is packed in baskets for delivery to the central linen room.

In 1951 it became necessary for Fairfield hospital to expand its facilities to take care of the increased amount of laundry required by the hospital and Laurel Heights Sanatorium. A 25 by 245 foot addition gave us the required floor space to rearrange present equipment and to install new automatic equipment.

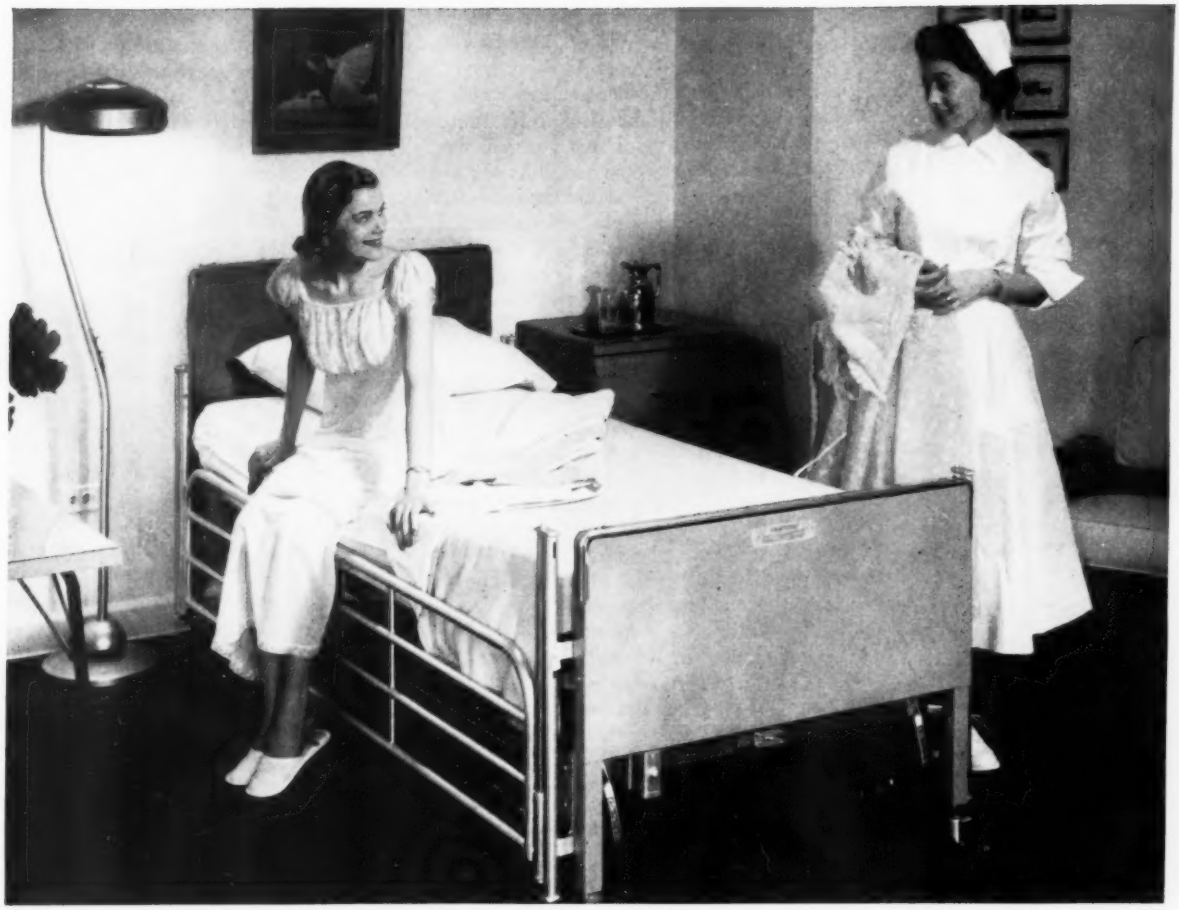
Upon completion of this expansion program we were able to discontinue the night shift, operate the laundry on a 40 hour week, and satisfy the laundering requirements of both hospitals. The total amount processed at Newtown for our hospital and the sanatorium is approximately 60 tons per week. To take care of this amount of linen we have 36 men and women employes and approximately 85 men and women patient helpers. The paid personnel in the laundry is maintained at an approximate ratio of one to every three patients.

We have 2875 patients at Newtown. There are about 832 employes living both on and off the grounds. The linen ratio for the Fairfield hospital is approximately 5½ pounds per patient day.

Today state hospital laundries are among the most modern in the country, equipped with fully automatic self-dumping wash wheels, preconditioning tumblers, conveyors, automatic sheet folders, and many other pieces of automatic and semi-automatic equipment.

The operation and maintenance of a hospital laundry is big business, and it is an important part of the over-all operation of any hospital. Many hospital laundry managers have been lax in keeping complete operating cost, maintenance and production records. No longer can a hospital laundry manager be slip-shod about this important part of the laundry operation.

Millions of dollars have been spent to build new hospital laundry plants and to expand laundering facilities in hospitals throughout the country. It is partly because of these large expenditures that hospital administrators are now more cost conscious than ever. Another factor is Blue Cross and other hospital plans which demand a more accurate laundry cost system. These organizations want a breakdown that



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Every feature of these truly modern beds is designed for patient safety and to save nurses' time. For instance, the full-length safety sides provide FULL-LENGTH, positive protection and never need to be removed—they lower out of nurses' and patients' way when not needed—can't interfere with bed-making or patient treatment. Famous Simmons two-crank spring permits a wide variety of posture positions. And every Vari-Hite bed has the sturdy, simple steel construction that cuts your maintenance costs! The facts are yours for the asking—write for them!

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will show the actual cost of bedside linen and the cost of linen furnished to operating room, delivery room, x-ray, and other departments which are involved in nonbedside care. The cost of linen in pounds per patient day is not sufficient, as it contains too many hidden costs, and comparisons among general hospitals are too variable.

General hospitals have always been cost conscious. But because of the large amount of money being spent by state hospitals to enlarge their present laundering facilities and the complete new laundries that are being built throughout the country, the state hospital administrators are also becoming both laundry and cost conscious.

A good laundry cost system is essential to the laundry manager and to his hospital. Large agencies like the Veterans Administration, army and navy laundries, hotel chains, and some states and large cities have complete laundry cost systems. These agencies also have laundry superintendents or laundry coordinators, whose job it is to supervise and coordinate all laundering services in their agencies or states, and it is compulsory for each laundry manager to submit a monthly cost form showing all expenditures for supplies, salaries and repairs, plus production and efficiency ratios.

Many times the excuse for not submitting a laundry cost report is that the laundry manager has no way of knowing the amount and cost of utilities supplied to the laundry, as there are no flow meters on his lines. The following chart can be used to measure cost of water, steam or electricity accurately. This method has been devised by the Institutional Laundry Managers Association of Connecticut and has been approved by the Connecticut Hospital Association for use in plants that do not have the means to measure their utilities and where accurate figures are not available. For convenience, water, steam and electricity are figured in pounds of linen processed.

Steam—$3.40 per thousand pounds of linen processed

Electricity—90 cents per thousand pounds

Water—3½ gallons required to process 1 pound of linen

Many articles have been written giving production figures for commercial, hotel and general hospital laundries, showing that flatwork production is higher than tumble work. These figures show that from 65 to 70 per cent of the total production is flatwork. Even the laundry machinery salesmen use this figure as a yardstick on estimates. The figure is correct for the aforementioned laundries, but not for state hospital laundries.

A good cost system will show that these figures differ. For example, the following are the average monthly production figures at Newtown, for Fairfield hospital only:

Flatwork	161,418 lbs.	37%
Rough dry	227,801 lbs.	53%
Press work	43,623 lbs.	10%
Total	432,842 lbs.	100%

There is a reason for this difference in production figures. A state hospital has many more items that have to be tumbled or rough dried, as the largest majority of patients are ambulatory, and many different items of clothing, material and blankets are used for their welfare and comfort.

Owing to the increased number of mentally ill patients plus the large expenditures made to expand existing laundry facilities and to construct new laundry plants, many states are not only compiling complete laundry cost systems that can be compared with those of other state hospital laundries, they are also considering appointing laundry superintendents or laundry coordinators whose responsibility it will be to coordinate all laundering and dry cleaning services in the states.

Many states have learned that by having a competent laundry coordinator their laundry operating costs have been considerably lowered, efficiency and production have been increased, and laundering standards have been raised to a point where considerable savings could be made by coordinating laundering and dry cleaning services.

PARTS SHOULD BE STANDARDIZED

State hospitals are usually located in the country, where machinery parts and factory trained servicemen are not always available. Serious thought should be given to standardizing laundry and dry cleaning equipment when purchasing new equipment. Laundry machinery manufacturers, like automobile manufacturers, standardize on parts so that they are interchangeable. Laundry managers should take advantage of this situation to eliminate too large an inventory of parts.

It is also good practice to keep a constant maintenance check on all laundry equipment. In large plants, it

is a good policy to have equipment operators report all apparent defects on their machines at once so that the machines can be inspected, adjusted or repaired before unnecessary damage occurs.

One of the best ways to keep equipment operating longer and more efficiently is proper lubrication. Our system has worked out very well. We use a pneumatic power grease unit which has a 25 pound grease capacity. This unit is mounted on three rubber-tired wheels and has 50 feet of air hose. Air chucks or outlets are located in various parts of the laundry building so that all laundry and dry cleaning equipment can be lubricated easily, with a minimum of effort. All grease fittings have been standardized so that this grease gun will fit on all equipment.

The following statement will evoke various responses from laundry managers, engineers and equipment salesmen, but I will stick my neck out on this one. I have removed all oil cups from our three flatwork ironers and have installed grease fittings in their place. The reasons for this are:

1. Owing to the amount of heat on ironers, oil cups cannot be adjusted properly, causing oil to stain both roll covers and aprons, sometimes to the extent that about eight inches on each end of the ironer rolls cannot be used for fear of contact stains.

2. Using oil creates a fire hazard on ironers as the oil drips down the sides, saturating the BX cable and accumulating in the channel iron at the floor level. When this oil mixes with lint, it becomes a definite fire hazard.

The system of replacing oil cups with grease fittings has been practiced here successfully for more than 15 years without a single bearing failure owing to improper lubrication. We also have full use of the 120 inch width of our rolls, as both rolls and aprons are free from grease or oil stains at all times.

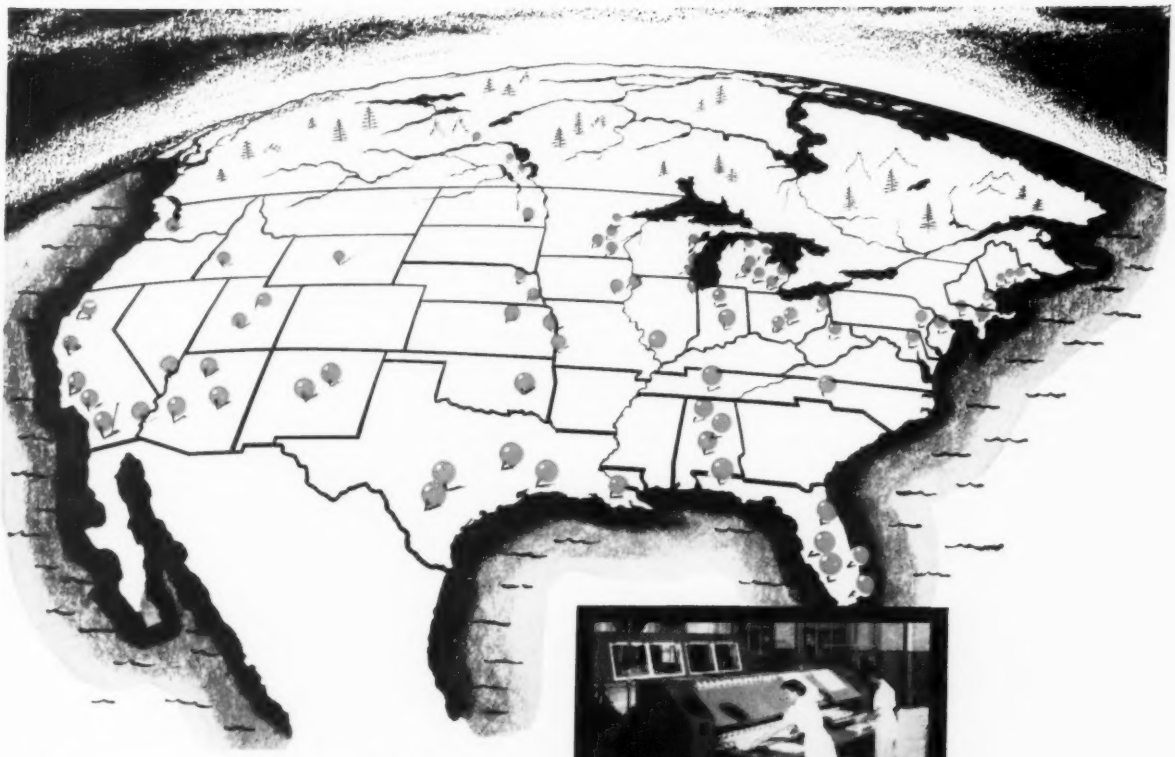
DRY CLEANING

An example of the progressive thinking of superintendents of state hospitals from the standpoint of economy and patient welfare is the incorporation of dry cleaning with laundering. Before World War II, a complete dry cleaning department in a state hospital was unheard of, but today dry cleaning is becoming an accepted and important part of the state hospital laundry.

During our laundry expansion program in 1951, a complete dry cleaning department was installed in the new section of the laundry. This is a 50 pound per hour unit, fully automatic and synthetic, using perchlorethylene solvent, two garment presses, one three-way puffer set, steam spotting board, prespotting table, scale, ironing board complete with a steam-electric iron, and one sewing machine. As this unit is both fireproof and explosionproof, it can be set up anywhere in a laundry building. It is approved by insurance and fire underwriters. This unit must be registered with the Department of Internal Revenue's alcohol tax division as it contains a still for reclaiming solvents.

It is now possible for us to dry-clean, press, mothproof and repair all patients' suits, overcoats and dresses, both personal and state furnished. We also dry-clean and press all draperies, slipcovers and many other items used in the hospital.

Now that package dry cleaning units are available and the charge system of dry cleaning has been perfected, more and more hospitals probably will install dry cleaning units in their laundries.



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A Training Program for Housekeepers

1. What It Takes to Be a Teacher

BARBARA D. MILLS

DURING World War II, I found myself, like many other department heads, perplexed with the problems of getting the job done. When employes who had mastered the job through tenure left for government or industry, there was no one with sufficient knowledge to take over. There was no selection of personnel for this type of work. It was here that I decided three things:

1. Top supervision is worth its weight in salary.
2. Standard basic procedures are a "must."
3. Training is the only solution.

After much discussion with management it was decided I might establish training programs for supervisors and service personnel. When these programs were established we started to live up to the things we understood instead of worrying about the things we did not understand.

I feel that now history is repeating itself. It is the shortage of trained housekeepers that has caused us all to sit up and take notice of the circumstances of today along with the possibilities of tomorrow.

In 1949, my program for executive housekeeping trainees was launched at St. Luke's Hospital, Newburgh, N.Y., with one trainee. I do not know how "formal" others might consider the content of that program. However, my administrator and I considered the

Mrs. Mills is director of housekeeping services, St. Luke's Hospital, Chicago.

TODAY'S executive housekeeper is constantly striving to establish new and better methods and procedures, and, at the same time, to improve her status in the hospital organization. The questions arise: "Do housekeepers now have—or will they ever achieve—equal status with other department heads?" "Does their remuneration compensate for the responsibilities they carry?" "Is recognition given to their increasing technical accomplishments?"

The time has finally come when housekeeping department leaders are devoting some time and thought to their own status, as indeed they must, to ensure their own professional growth and development.

We have done well, but the fact that we have done well in the past must not lead us into complacency. Rather, it must stimulate us to look for and correct our weak spots, and to overcome those problems which still persist in cropping up, as we strive to go forward with continued increase of duties and responsibilities.

How can this be done? There is only one way: education. I sincerely believe we are well under way in this respect. Many years ago, the National Executive Housekeepers Association started on the road to a sound educational program and we still are on the same road. However, progress has been slow, and for many of us, too much of life itself has slipped away. Suddenly we find ourselves in the autumn of our lives with little, if any, harvest to show for it. Now, at this time, we must ask ourselves: "What really matters most in developing a future for this organization?" "Which way are we going?" "How far are we going?" "Are we motivating and promoting our assistants toward a future of security?" For after all, our future is up to no one but ourselves.

To safeguard the future of the profession we must teach what we have learned to the people who will become our successors.

Following is a detailed explanation of the training program for executive housekeepers that I initiated at St. Luke's Hospital, Newburgh, N.Y., and have continued at hospitals in New York and Chicago. Other lectures in the series will be reprinted in succeeding issues of The MODERN HOSPITAL.

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PROJECTED STIPENDS FOR HOUSEKEEPING TRAINEES

No. 1

1st six months:	**Complete maintenance with $40 a month.**
2d six months:	**Room and laundry with $40 per week.**
Last six months:	**Assistant supervisor's salary with the first increment upon graduation.**

No. 2

1st nine months:	**Stipend same as given trainees or interns in other departments when maintenance is not available.**
2d nine months:	**Assistant supervisor's salary with the first increment upon graduation.**

training to be on a formal basis, even though the size of that hospital would permit only one trainee at a time.

WHO SHOULD BE TRAINED?

Anyone with the desire to learn to be an administrative housekeeper is considered eligible for the program. The majority of my trainees are beginners, coming to me from a housekeeping preparatory school or through channels of advertising. Nevertheless, there is no reason any of the employes within the department cannot be trained if they are potential material. This climb up the ladder does not "just happen"; it requires considerable work and study. It takes a great deal of study to become a specialist.

WHO DOES THE TRAINING?

That is a $64 question. Most people will say: "The housekeeper, of course, is the person best suited to do the basic training; she is the best informed on job analysis and procedures." But really, it is not that easy, for one must take into consideration the status and scope of the housekeeper, as well as the department, and this brings many factors up for consideration. Following are a few of them.

First, there is the institution that hires someone called a housekeeper—and she is just that, with little or no authority and very limited capacity.

Second, there is the institution that has only a working housekeeper, and the orders and schedules come from someone much higher in authority. When asked if she would like to try instructing her workers on the way things should be done, she replies: "Heavens no! No one would listen to me; they don't think I know anything. They go to the big boss with everything."

Third, there is the organization that has a person with the title of executive housekeeper, but she is completely apathetic and is neither interested nor ambitious to improve herself or her department. Why? "The boss is not interested in this department. I can't get any equipment and you know the high school kids make more money than I do, so why kill myself! You know, I'd quit before I would stand up and tell these people how to work. Besides, my feet hurt too much for all that standing."

Fourth, there is the organization with an executive housekeeper—but in name only. She is alert and ready to advance by research and study; she has a potential for leadership, but the administration fails to see any reason she would need either time or money budgeted for the improvement of the department.

In fact, "What is there to learn?" the administrator wants to know. "You have been with us for years doing a good job and what can they tell you in a school or institute that you don't already know? Why, I bet you could tell them a thing or two about sweeping and cleaning!" And then when the discouraged individual asks, "Why is it that the heads of other departments can have these advantages?" she sees the frown disappear and a pleased voice informs her: "Well now, that is different. The other departments need to be well informed on the latest things in order that they may give the best service to the patients."

Sometimes administrators do take advantage of such ambition and interest, but too often they fail to see that housekeeping has come a long way from the rag mop and dustpan days and that we are not a "necessary expense" but a key department. Housekeeping is fast becoming a science, which requires skilled personnel to grapple with the problems.

Fifth, there is the executive housekeeper whom the organization employed to organize and train throughout the department. But don't think for a minute that her problems are over, for she will still hear: "Why do you want to do that? We have done it this way for the last 20 years, and it works all right."

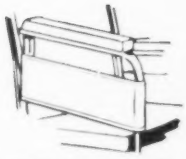
It is moments like these that make one wonder if it is ever possible to trust human nature. However, the housekeeper patiently endeavors to show the administration how the best results can be obtained.

From this outline one can understand that many housekeepers are not ready to accept the rôle of true leadership. For, if a training program is to be undertaken, the teacher must have the qualities that will make the structure sound. It does not take a college degree to obtain these qualities, but it does require continuous study, research and observation, plus long experience and the patience and understanding that come with experience.

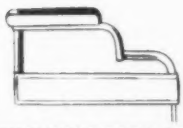
We must look to administration to give us a helping hand in establishing a standard for executive housekeepers, and then live up to these requisites. Administration is not entirely to blame for the situation in which we find ourselves. What have we done to give our administrators any incentive to entrust us with the responsibilities of a leader? How good has our salesmanship been? Have we tried to time his thinking to ours? Have we been patient and repeated our efforts to explain our plans and ideas for the department? Have we proved our worth beyond doubt?

Every time the nursing department has requested housekeeping to handle additional duties, do you take advantage of it? Do you see this request as an opportunity for your department to expand as well as an opportunity to show the ability to organize? Too often, such a request is met with defiance and a "they won't push me around" attitude, which certainly calls for no recognition or consideration from anyone. If you want to do a man-sized job it is necessary to act like a lady and think like a man! Humility never hurt anyone.

Training means teaching and to teach means to impart all possible information on the subject under discussion so that the trainees learn every facet of the job. It has been my experience that in order to do a good job of teaching the housekeeper should be able to do everything that she ex-



REMOVABLE ARM



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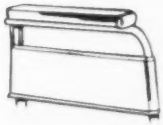
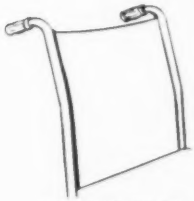


RIGID PADDED ARM



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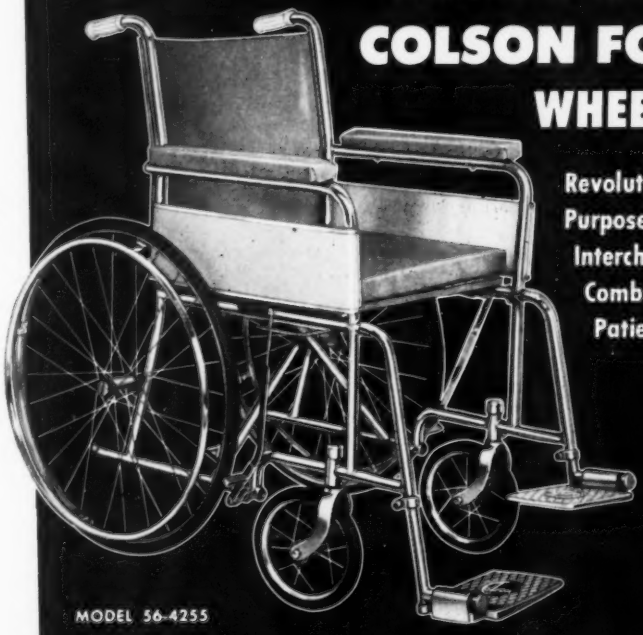

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TRAINING PROGRAM FOR EXECUTIVE HOUSEKEEPING TRAINEES

Part 1. Administrative Subjects Required: six weeks (five 8 hour days each) of lecture, research and study.

W.W.W. Club (Walk, Watch and Write): eight weeks (five 8 hour days). Student accompanies each supervisor for a limited time and learns procedures and human relations from floor observation.

Participating Programs: three weeks

Motion and Time Studies: two weeks (carrying out the study to the function of the procedure and putting procedure into use).

Projects: Plan, organize and function with follow through—three weeks.

There are no time limits on the following, but this part of the program usually takes four or five weeks.

Cover secretary's desk in the office.

Master the payroll, time books, inventory and personnel records, and various forms. Learn good lines of communication and follow through, directing service personnel, together with secretarial duties. Four weeks (five 8 hour days each).

Written examination. Total time—six months.

Part 2. Procedures and Practices

The major part of this material is taught through participation. However, after several months of handling personnel, the trainee receives her assistant supervisor's pin, and the remainder of the functions are taught during the next four months, as the trainee develops in a supervisory capacity.

Laundry: 80 hours of participating and observing.

Budget and Cost Control: Four weeks (five 8 hour days each).

Field Work:

Two conventions, workshops or assemblies

Mattress and pillow factory

Decorating and furnishings

Floor coverings

Upon completion of the program, a diploma and pin are given to the student by the hospital administrator. If these students are from the Hannah Harrison School in Washington, D.C., they will have received their school diploma at the end of the six months after the written examination.

Training is everything.

---

pects of her service personnel and staff. If you know how to operate housekeeping equipment, it is simple to pass this knowledge on to others. This is important, whether you are a "one-man band" or have a staff of assistants. You certainly cannot have efficient assistants or supervisors unless, together with their basic training, you give them access to your knowledge and experience by continuously maintaining efficient supervision and good personnel relations. Those last two, to my way of thinking, are the secrets of good management.

HOW, WHEN AND WHERE?

1. Training the staff. Experience has proved that this is the foundation and answer to a well organized, harmonious and constructive department. In our hospital, a person hired for the position of assistant, who has had previous experience, is given four months' training under the direction of a trained supervisor. During this time, she writes up each day what she has learned and observed. This is given to me to check and return with comments if needed. This training period comprises a highly concentrated program on appearance and behavior. Interdepartmental and intradepartmental relationships, human relations, staffing, distribution of the work load, and scheduling are other phases of the training.

A room representing a typical patient area is set up for actual supervisory training. At the end of the four months, trainees are given both written and oral tests, and if no further training is necessary they become assistants sponsored by the supervising housekeeper.

A monthly meeting of the entire staff is held to pass on new ideas, problems, general discussion of work, and procedure changes.

2. Training service personnel: aides, housemen and floor mechanics. All new service employes are given one week's training supervised by one of their co-workers, doing the same type of work for which they have been employed.

I believe in promoting from within wherever it is possible. I have experienced excellent results by allowing sponsors to "belong" to those over whom they exercise control. This can be done by selecting from trained personnel one houseman and one aide whom you believe from past performance are able to assume the responsibility of training a new co-worker. This training is done right on the job in the area to which these selected workers have been assigned. Procedures and timing, handling of equipment, conduct and personal relationships are the things we stress in this training center. The trainee stays with the sponsor for one week and from time to time is taken into the area for which he was employed. This is done to make him acquainted with the area in which he will work.

After the first week, the new employe is on his own with the sponsor looking in now and then and, of course, helping when it is necessary. If, during this second week, a supervisor finds the new worker doing something wrong *she* does not correct the problem but goes to the sponsor and asks him to follow through. After the second week, the supervising housekeeper is responsible for the workmanship and further training of the new personnel. Concrete proof of the value of this training is shown in reduced production costs.

In addition, two training classes are scheduled per month for one hour each, sometime during the working day in one of the classrooms or lecture areas. One class is devoted to attitudes and appearance, discussion of complaints, interdepartmental and intradepartmental relationships, personnel activities, and anything else that may require group thought and discussion.

Here the executive housekeeper has the opportunity to discover many capacities latent in the individual employe that may be put to use before too long. Also, quite frequently, she can help change a life by changing the attitude of a person. I have found that many times older employes are responsible for straightening out wrong

conceptions and attitudes of new coworkers. Respect and consideration for one another, regardless of position, help to make a happy, trustful and healthy department and, if you want to give trainees a real shot in the arm, tuck in some planned recreation.

3. Training the executive housekeeping trainee. Standard procedures must be established and taught to all those in supervisory capacities because all housekeeping trainees must get their working knowledge by accompanying the present supervisors or assistants on their rounds. Believe me, it takes a student unknowingly to highlight some of the old-timers' errors. Hence, the necessity of all functioning alike.

Outwardly the capacity of the classes is guided by the size of the hospital, the attitude of the administration, and the budget. However, way down deep, it depends on salesmanship. The executive housekeeper must be thoroughly sold on the idea of the training program. There is "a time to every purpose." If you bear this in mind when you decide to make known your willingness to sacrifice your time and efforts to establish such a program, I am certain any administrator will make every effort to meet you halfway. I believe the day has arrived when management realizes it is most unhealthy not to give the executive housekeeper a range of freedom in which she can grow.

For the past few years my classes have consisted of four students because the hospital is large enough to warrant this number and my administrators have been wholeheartedly in accord with training for the field. I don't suggest that anyone should tackle this number for the first program. Take one trainee for your guinea pig. Get the pattern established before you expand. There will be times when you will be sure you have lost your mind for ever starting such a program. You will certainly lose your sense of values some time or other and have to ask yourself what is really important: to give someone an opportunity to learn a profession—from which some other organization will probably benefit—or to remain complacent and selfish, convincing yourself that the future of your chosen field doesn't really concern you. Although I am really past the actual "testing point," I can never afford once to forget that I earn my right to tomorrow by the way I do my work today.

This entire training program covers 18 months, with increments given in accordance with the trainee's growth, as shown in the outline for salary projections on page 140. Stipend for the trainee has always been in accord with the practices of the organization.

At the completion of 18 months of satisfactory work the junior executive housekeeper moves on to fill the place awaiting her. The only stipulation is that, while she can handle a small hospital as her first charge, she should expect to serve as an assistant in any institution of more than 250 to 300 beds. If another class does not succeed the graduating class, the students may remain for further development but without additional salary since the budget is set to cover a stipulated amount. Therefore, unless the junior executive housekeeper becomes a part of the housekeeping staff, her salary must remain at the second increment of the assistant supervisor. After 18 months of training, our graduates have learned that until one has the capacity to understand, she cannot explain to another, so our trainees usually stay as long as possible to gain experience.


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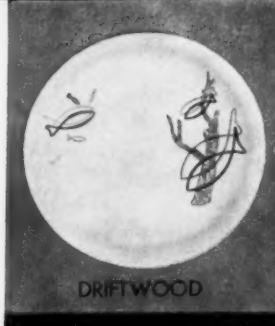
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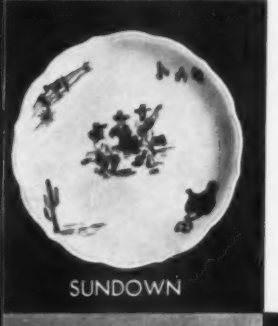
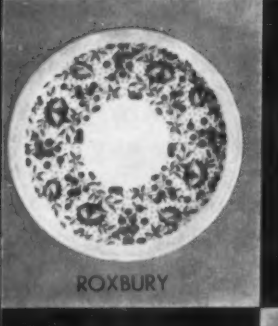

SUNDOWN

There's a New TREND in China
(See next page)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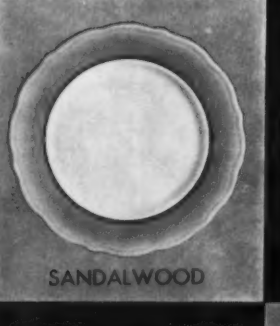
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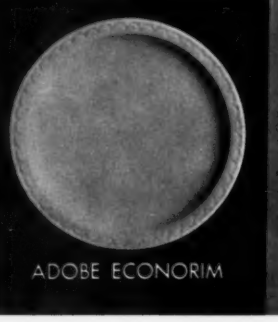
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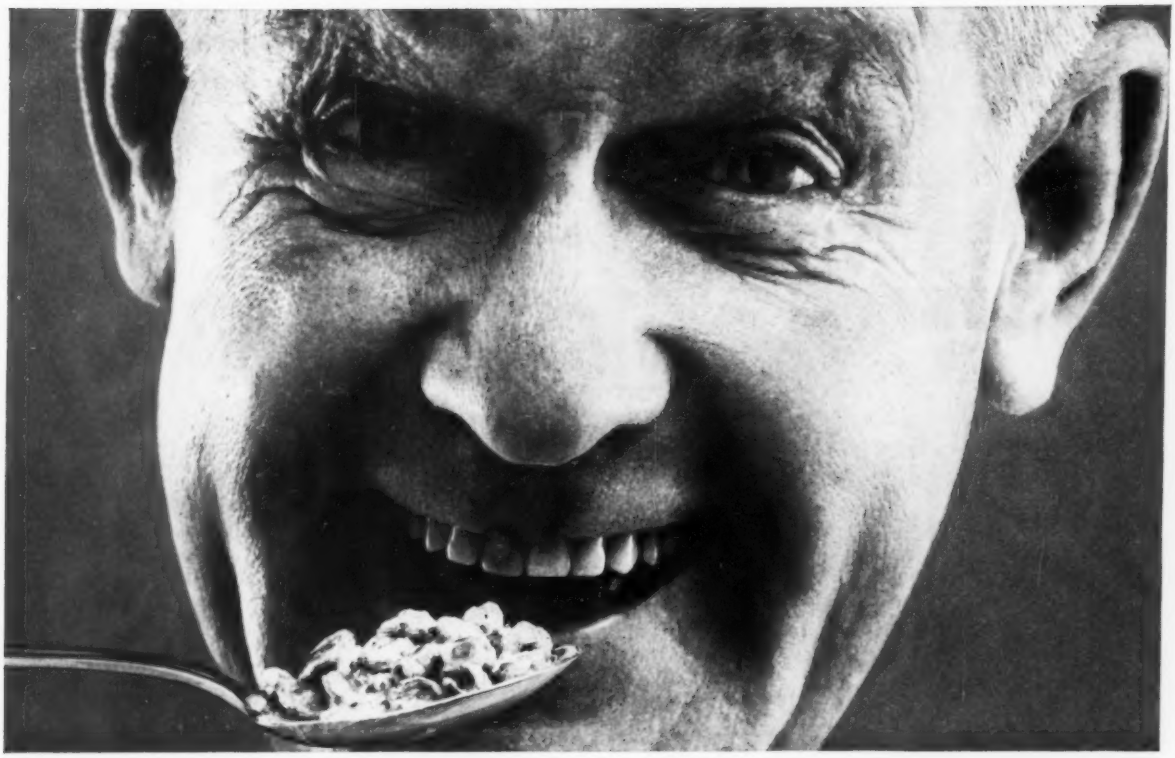


Quaker Variety... the "spice" of low-sodium diets

There's no need for breakfast monotony in low-sodium diets when you serve Quaker cereals. The Quaker cereals listed here—quick cooking, regular or ready-to-eat—*every* one is low in sodium content.

But these Quaker cereals are more than just "diet" foods. They're wonderful eating—loaded with tempting flavor that has made them favorites for years on America's breakfast tables.

Why don't you start serving a variety of these Quaker cereals in your hospital soon, and recommend them to all your low-sodium diet patients. These cereals are easy for your diet patients to get—right off the shelves of their neighborhood grocer.

Free diet cards. Personal diet cards for you to give your patients are available free from Quaker. They provide space for you to list diet foods and also indicate Quaker low-sodium products. Write for the quantity you need. Institutional Sales, The Quaker Oats Company, Chicago 54, Illinois.

Sodium Content of Quaker Cereals (Typical Analysis)	
Hot Cereals	**Mg/100 gms.**
Quaker Oats	3
Quick Quaker Oats	3
Quaker Enriched Farina	2
Pettijohns (Rolled Whole Wheat)	2
Ready-To-Eat Cereals	
Quaker Muffets (Shredded Wheat)	4
Quaker Puffed Rice (Enriched)	4
Quaker Puffed Wheat (Enriched)	6

Providence Hospital Is Modern Hospital of Year

(*Continued From Page* 80)

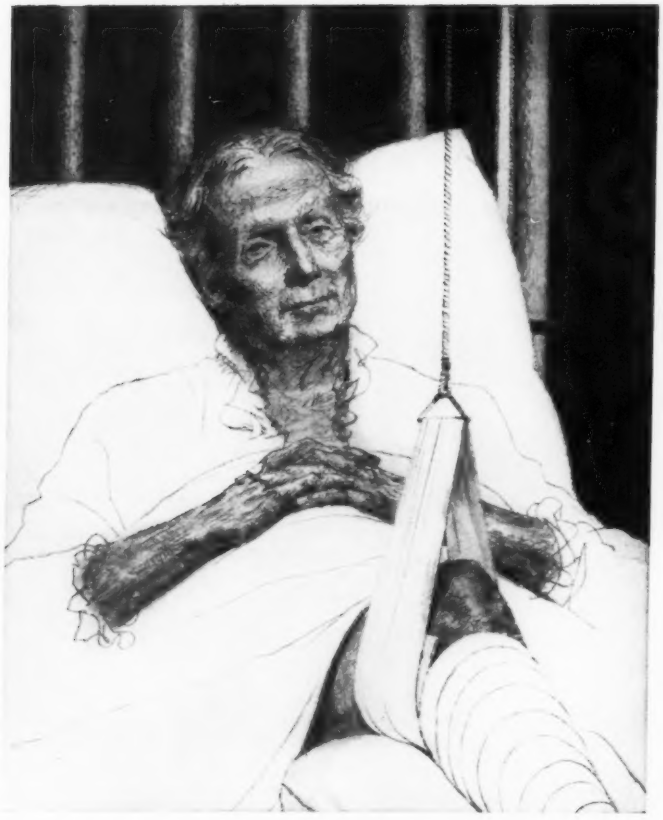
Dr. Thomas E. Curtin, director, outpatient department: "The planning of the outpatient department has provided many advantages. The spacious general waiting room and registration area tends to reduce the mob appearance of a busy clinic. Separate smaller waiting rooms in each clinic department make for more order and content among the patients. The addition of a second large waiting room on the second floor is likewise a major factor in reducing the confusion at the main desk. Complete division of the various clinics, consultation and treatment rooms, as well as nursing counter and clerical space, is most advantageous.

"The lighting system and soundproof ceilings enable a busy department to be conducted in a cheerful, quiet, professional air befitting a luxurious office rather than the conventional clinic. A separate conference room enables the outpatient department personnel to pursue its educational schedule wholly independently of the busy conference rooms in the main hospital.

"Other physical factors that contribute to the smooth operation of the outpatient department are the provision of a separate physicians' call board wired to the main call board in the hospital lobby; the construction of the outpatient department as a wing of the hospital, thus affording direct intercommunication with the hospital while at the same time maintaining desirable separation; the convenience of separate elevator service, and the close proximity to the laboratory, x-ray and heart station."

Members of the committee making the selection of Providence Hospital as "Modern Hospital of the Year" were: Carl A. Erikson of Schmidt, Garden & Erikson, Chicago; August H[illegible], chief, Architectural and Engineering Branch, Division of Hospital and Medical Facilities, Public Health Service, Washington, D.C.; Dr. Jack Masur, assistant surgeon general of the Public Health Service and director of the Clinical Center, National Institutes of Health, Bethesda, Md., and Everett W. Jones, technical adviser to The MODERN HOSPITAL.

Another hospital receiving consideration in voting by members of the committee was the Madison East Building of the Baptist Memorial Hospital, Memphis.



weeks?

months?

years?

Improve the prognosis in fractures with "Premarin" with Methyltestosterone

Healing of fractures is often delayed because impairment of osteoblastic activity due to declining sex hormone function causes the bone matrix to atrophy.

Older patients with fractures, particularly of the hip, respond well to combined estrogen-androgen therapy. The prognosis for bone recalcification is good provided treatment is continued for extended periods.*

*Reifenstein, E. C., Jr., in Harrison, T. R.: Principles of Internal Medicine, ed. 2, New York, The Blakiston Company, Inc., 1954, chap. 98, pp. 702, 703.

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Excellent preparation for estrogen-androgen therapy

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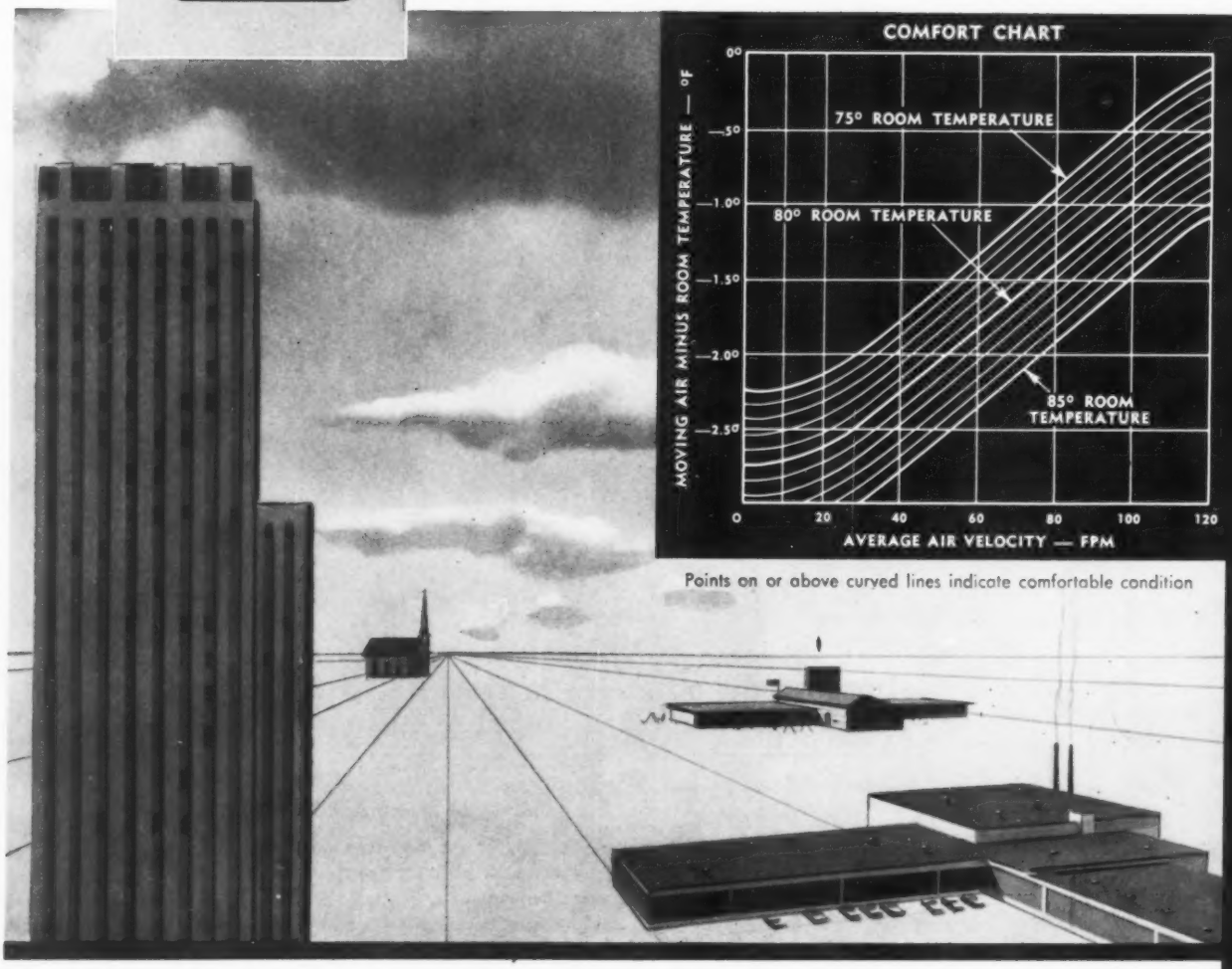

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Creative team engineering at Barber-Colman Company effectively combines the modern advances of automatic temperature controls and engineered air distribution for performance-guaranteed results. Write for descriptive literature . . . or ask your architect or engineer about this exclusive "one responsibility" feature of Barber-Colman products and service.

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COME TO ONE SOURCE...COME TO.....

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Barber-Colman combined products assure proper relationship of velocities and temperatures for constant comfort . . .

To the occupant of a building, what instantly marks the difference between a properly functioning air conditioning system and a poor one?

The correct system provides draft-free, quiet, *uniform distribution of the air . . . at a constantly held, comfortable temperature*, regardless of outside temperature changes.

The incorrect system varies from "too warm" to "too cool," or "too drafty." Although it may be delivering exactly the same amount of conditioned air, it is not engineered to maintain proper relationship between *velocities* and *temperatures.*

Constant maintenance of this relationship is of extreme importance, because a person's feeling of warmth or coolness is affected by: (1) room temperature, (2) velocity of conditioned air being introduced to the room, and (3) temperature of moving air in relation to average air temperature in the room. To maintain the correct relationship of these variables and stay within the requirements shown in the Comfort Chart at left, there must be closely co-ordinated functioning of the system's *automatic controls and its air distribution units.*

Such performance is assured when you install Barber-Colman Electrionic Automatic Controls and Uni-Flo Engineered Air Distribution. For Barber-Colman has long years of *combined experience* in both automatic controls and air distribution — *and assumes one responsibility* to bring you ideal "indoor weather." Call your nearby Barber-Colman Field Office, or consult your architect or engineer.

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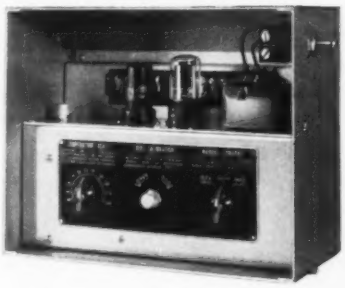
MOTOR-OPERATED VALVES–Wide range of sizes and types.



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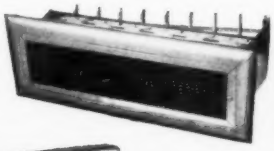
Illustrated here are but a few of the modern automatic controls available from Barber-Colman. This company has a remarkable background in design, engineering, and precision production of fine equipment. Our field staff is widely experienced in solving all types of temperature control and air distribution problems.



UNI-FLO SIDEWALL DIFFUSERS–For quiet, draft-free air conditioning, heating, ventilating. Adjustable air patterns. Various frame styles.

UNI-FLO SQUARE AND RECTANGULAR CEILING DIFFUSERS

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Uni-Flo Engineered Air Distribution

In addition to Uni-Flo units shown above, Barber-Colman Company produces a complete line of air distribution products for better air handling. Make this your source for reliable performance data and fine-quality equipment . . . take advantage of the continuous flow of new developments from the renowned Barber-Colman Laboratory.

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NEWS DIGEST

A.H.A. Midwinter Meeting Spotlights Group Dynamics . . . Washington State Nurses Seek Collective Bargaining . . . Specialists Talk Back at A.M.A. Congress . . . Two Nursing Home Fires Kill 86 . . . A.H.A. Calls Special Delegates Meeting

Group Dynamics Takes the Spotlight at A.H.A. Midwinter Meeting in Chicago

CHICAGO.—Instead of sitting and listening to speakers tell them about association problems and activities, as they are accustomed to doing, the 175 delegates to the American Hospital Association midwinter meeting here February 4 and 5 did all the talking themselves.

Immediately following the opening session Monday morning, they were divided into eight "workshops," each devoted to a major problem confronting hospitals and the association. Each group, headed by a discussion leader, discussed its special topic and appointed someone from the group to report to the general assembly at the Monday afternoon and Tuesday morning sessions. Subjects covered included: (1) administrative operation of hospitals; (2) relations with regional, state and local hospital associations; (3) hospital associations and Blue Cross; (4) hospital care for federal employes; (5) program for directors of hospital volunteers; (6) the hospital as a center for health services; (7) relationships of hospitals to all types of prepaid hospitalization and insurance plans, and (8) nursing problems.

This "group dynamics" technic, A.H.A. President Albert W. Snoke explained, was intended to stimulate the exchange of ideas and opinions between the national association and the state and local groups. Some objections to the procedure were voiced by delegates who felt that the groups just weren't dynamic enough. Either the discussions were rambling and inconclusive, they contended, or some zealot pounced on a trivial and irrelevant facet of the general topic and worried it—and his colleagues—to death.

In spite of these problems, the groups faithfully reported their conclusions, or lack of them, at general sessions on Monday afternoon and Tuesday morning. And at the Monday meeting at least, the discussions from the floor became quite dynamic on two or three occasions, notably when the touchy subject of "Medicare" came up.

"Medicare," it developed, is still a very sore point between hospitals and the Blue Cross. After hearing Robert T. Evans, chairman of the Blue Cross Commission, report on the first 30 days' experience with the program, various delegates offered comments indicating that feelings are still running high in some quarters. First, a Massachusetts delegate pointed out that his state objected to the A.H.A.'s acceptance of Blue Cross reimbursements because "we can't get anywhere with Blue Cross."

Next came Harry Panhorst, associate director of Barnes Hospital, St. Louis, and president of the Missouri Hospital Association, who reported somewhat diffidently that Missouri, which is in the commercial insurance area, was in the somewhat embarrassing position of having to admit a very happy experience with Mutual of Omaha.

"They answer every one of our questions promptly, pay up at once, and are doing a fine job all around," said Mr. Panhorst. "It's very frustrating—we can't build up our case for Blue Cross as things are." This view was supported by Duane E. Johnson, Nebraska association president. Hospitals in Nebraska are having the same experience, he said.

Asked by the chairman if he wished to answer these statements, Mr. Evans replied glumly: "No comment." However, Edward K. Warren, trustee

(*Continued on Page* 168)

Medical Schools and Specialists Bite Back at Critics in Spirited Session on Education

CHICAGO.—Medical schools and specialists bit back last month at some of the groups that have been criticizing medical education and specialism during the last year or two.

Speakers at the 53d annual Congress on Medical Education and Licensure sponsored by the Council on Medical Education and Hospitals of the American Medical Association did not mention any names, but, plainly, their targets included the American Academy of General Practice, several state medical societies that have been haranguing against "the practice of medicine by tax supported medical schools," and, by implication, the House of Delegates of the A.M.A. itself, which last year approved a policy statement condemning private practice by full-time members of medical school faculties.

"Whether we like it or not, specialization is here to stay," declared Dr. Herman Weiskotten, who will retire this year as chairman of the council. "Failure to specialize would deny to the public the many benefits of advancing medical science," he added.

Critics who claim today's medical schools are turning out technical specialists who neglect the patient as a person, rather than practitioners of medicine, are wrong, Dr. Weiskotten said. However, Dr. Weiskotten himself criticized the practice under which many medical students decide on a specialty while they are still in medical school.

Medical students are wrong to "sell themselves in bondage to certain types of medical practice," he explained.

In another address at a session on "Medical Education Tomorrow," Dr. Dana W. Atchley, professor of clinical medicine at Columbia University College of Physicians and Surgeons, New York City, denied that specialists lack

(*Continued on Page* 178)

Standard of all Comparison

HERRICK STAINLESS STEEL* REFRIGERATORS

INSULATION: Semi-rigid Fiberglas 2½ lb. density, 3" thick in walls, 3⅝" thick in doors, protected with 3-ply vapor barrier paper sealed with asphalt compound.

FINISH: Exterior front and ends stainless steel No. 4 finish. Remote models available with white porcelain and self-contained models with white baked enamel exterior. Interior lined with stainless steel 20 ga. No. 4 finish. Also with white porcelain interior.

CONSTRUCTION: All corners on front vertical and top front and ends rounded 1½" radius. Interior corners rounded ½" radius.

LIGHTS: Interior lamps on vertical mullions controlled automatically by door switches.

DOORS: Heavy duty construction. Exterior edges rounded on ½" radius. Grease resistant extruded neoprene gasket door seal. Door liners are sanitary one-piece construction.

HARDWARE: Heavy cast brass chrome plated. Surface type hinges, 6½" strap ball-bearing type. Latches automatic. Adjustable strike and padlock eye.

SHELF SUPPORTS AND STANDARDS: Polished stainless steel. ½" adjustments in ht.

BREAKER STRIPS: Door openings lined with odorless, polished Bakelite breaker strips, ⅛" thick, edges rounded.

SHELVES: Heavy ⅜" frame round wire construction with cross-wires. No. 10 gauge. Electro-welded, bright zinc with baked lacquer finish. Also available in stainless steel round wire construction.

COILS: Oversize cooling surface area. Air drawn in by fan and discharged out the bottom through integral louvered drip pan for a minimum temperature difference from top to bottom. Coil housing is aluminum.

TRAY SLIDES: (Available in place of shelves). Angle type in 16-ga. stainless steel, welded to vertical support angles and removable in sections for cleaning.

CONDENSING UNIT: Accessible, hermetic, heavy-duty type. Proper balance with cooling coil for 12° T.D. between coil and inside cabinet temperatures. Trouble-free performance in busy, hot kitchens.

COMPRESSOR COMPARTMENT: Removable access panel with maximum ventilation openings for efficient cooling. Large compartment for greater air circulation and lower ambient temperature.

DRAIN: Depressed gutter with cast brass cleanable drain trap.

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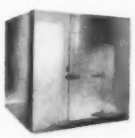

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Grady Memorial Hospital
Atlanta, Georgia

Toledo Hospital
Toledo, Ohio

Two Nursing Home Fires Kill 86 Patients

WARRENTON, MO.—An investigation into the cause of a fire which took the lives of 72 persons in the Katie Jane Memorial Home here February 17 has revealed that the fire apparently started in or near a first floor linen closet at the rear of the home's three-story main building. The source may have been a cigaret or match tossed on the floor or in a trash can, according to investigators who questioned W. S. O'Sullivan, operator of the home, several members of his staff, and several surviving patients.

The flames spread from the corridor into both the main building and annex so that the structures burned simultaneously, witnesses said. Many doors and windows were open because of the warm day, and breezes from outside supplied draft for the flames, they added.

According to Mr. O'Sullivan, the building had been fully inspected the previous week by the state inspector of nursing homes and had been given approval as complying with state regulations. A two-year program of rewiring, redecorating and remodeling had just been completed, Mr. O'Sullivan said.

However, according to a *New York Times* report, the home, one of eight run by the same family in Missouri, had been operating without a license, pending a thorough check of wiring, improvement of sanitation on dishwashing methods and preparation of more complete medical records.

More than 190 persons were living in the building, which once served as a women's dormitory for defunct Central Wesleyan College.

Gov. James T. Blair Jr. said in Jefferson City that he would recommend a tightening in state laws regarding nursing home inspection when he has studied results of the investigation. He called present laws "completely inadequate" after he was informed by Dr. James D. Amos, director of the state division of health, that present laws in Missouri do not require safety installations, such as fire escapes, sprinkler systems, and similar devices in nursing homes.

Iowa Nursing Home Fire Kills 14; Cause Unknown

COUNCIL BLUFFS, IOWA. — The cause of a fire that killed 14 patients in a nursing home here last month remained undetermined as local and state fire department officials undertook an investigation.

There were 43 patients and employes in the 71 year old, three-story building at the time the fire broke out, it was reported.

Seventeen patients were evacuated or escaped during the fire. Of these, several needed hospital treatment.

The home was operating under a suspended license, pending "certain corrections" of state regulations, the state health commissioner's office reported.

Left: A grim rescue worker and fire officer carry the body of one of the 14 victims of a convalescent home fire in Council Bluffs, Iowa, while nurses in the background work over another fire victim. Below, left; Aerial view taken February 18 shows the ruins of the Katie Jane Memorial Home, Warrenton, Mo., in which 72 persons died. Below, right: Survivors of the Warrenton fire are cared for in an undamaged portion of the home. (United Press photos.)

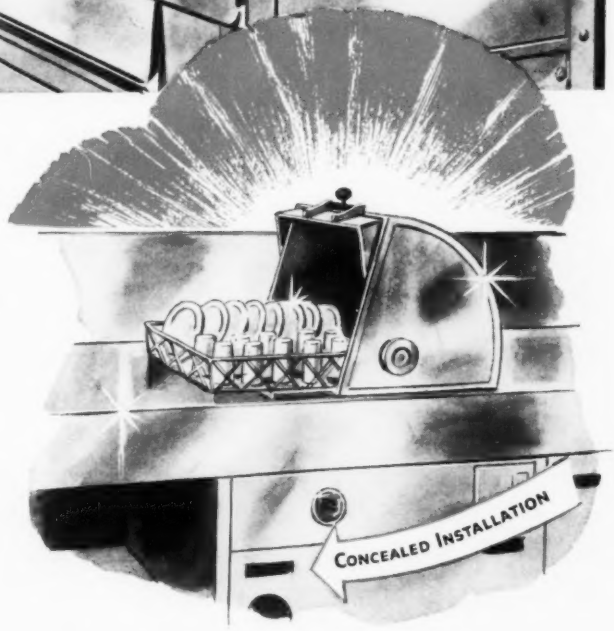
NEW *Drymaster* ON ANY DISHMACHINE

DRIES DISHES, GLASSES, SILVER FOR ONLY 21¢* A DAY!

Any make, model or size dishmachine can be equipped for automatic drying with Economics Laboratory's new, low-cost rinse injector, "The Drymaster." So compact it fits anywhere. So low in price, every dishroom can afford it.

21¢ a day installs your "Drymaster." And you can forget about maintenance! It's guaranteed, built with watch-like precision. No electricity. No gadgets.

With a "Drymaster," dishes come dry, gleaming and spotless—right from your dishmachine. Proved in thousands of dishrooms, the "Drymaster" can cut costs by as much as 25%! Get the whole story today by calling the SOILAX sales office listed in your phone book. Or write to:



*Covers basic unit price

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The most important advantage of the American Wheel Chair Line is its complete adaptability to fit varying patient requirements. Almost every patient—regardless of size, age, or ailment—can be accommodated by American's basic models, attachments, and adjustments.

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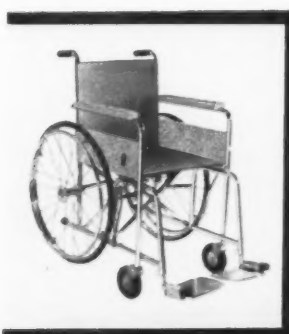
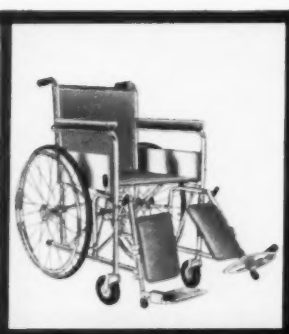
The American line offers a complete selection of models—from standard units to Electromatic self-propelled wheel chairs that take the patient virtually anywhere that a nurse can—all at the push of a button.

These superior units are manufactured by American Wheel Chair, Division of Institutional Industries, Inc., for distribution to the hospital field by American Hospital Supply Corporation. In their design, engineering, and performance, they are the finest in the field. They represent another example of American's unceasing efforts to ease the burdens of hospital personnel—and to reduce the costs of hospital administration.

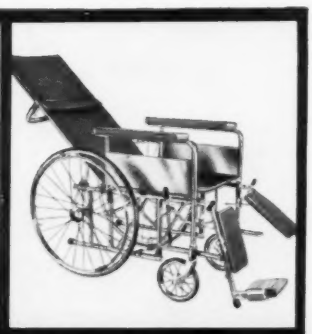


The Pacesetter—Built for style, comfort and economy. Constructed of high grade furniture steel tubing in a sparkling chrome finish. Shown here is the Pacesetter with Telescopic Footrests . . . one of 20 diversified models. Permits greatest freedom of choice in the low price range.



The Leader—Quality crafted for lasting service. Unrestricted selection with 20 distinctly different models to choose from. Illustrated here is the Leader with Adjustable Legrests. The Leader is a deluxe chair with jar smothering Flexiride Frame and hidden X members.

The Supreme—For those who want the finest. Standard Removable or Removable Desk Arms to make easy transfer from chair to bed, car, etc. 40 models meet virtually all possible patient requirements. Pictured is the Supreme with Removable Desk Arms and Swinging Footrests.



The Triumph—Multi-position back . . . relief for those requiring utmost comfort. Rugged construction with either Standard Removable Arms and Removable Desk Arms. Broad selection—20 models to choose from. Above is the Triumph with Standard Removable Arms and Adjustable Legrests.

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A.H.A. House of Delegates Called to Special Meeting

CHICAGO. — A special meeting of the house of delegates of the American Hospital Association has been called for 9:30 a.m., March 16, at the Drake Hotel here.

At this meeting, the board of trustees will bring to the house the report of its deliberations with reference to the recommendation of the house, passed on Sept. 17, 1956, that the board consider "the organization of a formal campaign to raise a substantial sum through voluntary contributions to be received from member hospitals and/or others. . . ."

At the direction of the board, Dr. Edwin L. Crosby, secretary, issued the official call to the house on Feb. 8, in accordance with Article X, Section 5 of the by-laws requiring 30 days' notice of meetings of the house.

Three special committees of the board have studied the recommendation. The board has considered it at two regular meetings and has decided that the report now should be brought before the delegates for their discussion. The March 16 meeting will permit the delegates to consider the matter and then return to their states for further discussions with member hospitals before acting on the report at a subsequent meeting of the house, tentatively planned for May 18.

A.C.H.A. Announces Scholarship Grants From O.F. Ball Fund

CHICAGO. — A scholarship grant of $1500 to encourage graduate students in the field of hospital administration was announced here last month by the American College of Hospital Administrators.

The grant will be made from the Otho F. Ball Memorial Fund of the college, it was explained in an announcement made jointly by the college and Raymond P. Sloan, chairman of the board of directors of The Modern Hospital Publishing Company.

Dr. Ball was founder of The MODERN HOSPITAL and president of The Modern Hospital Publishing Company until his death in 1953.

The grant, to be known as an "extended residency scholarship" will be administered under the postgraduate training award program of the college and will be used to encourage graduate students to undertake continuation study in hospital administration.

Under the grant, the scholarship fund may be applied either for an additional year beyond the master's degree requirements, to be spent at the university under the guidance of the course director, or for an extended residency period in a hospital under the guidance of an acceptable preceptor.

Basis of the award shall be evidence of satisfactory scholastic attainment, it was explained; evidence of intention to practice in the field of hospital administration; evidence of sincerity of desire and objectives in seeking extended residency training; evidence of need for financial assistance, and evidence of good character and other attributes thought necessary for success in the field of hospital administration.

Applications for the postgraduate training awards may be obtained on inquiry to the college, it was announced. The scholarship committee will consider all applications as soon as possible after March 1, in order that awards may be announced prior to the beginning of the extended residency period July 1.

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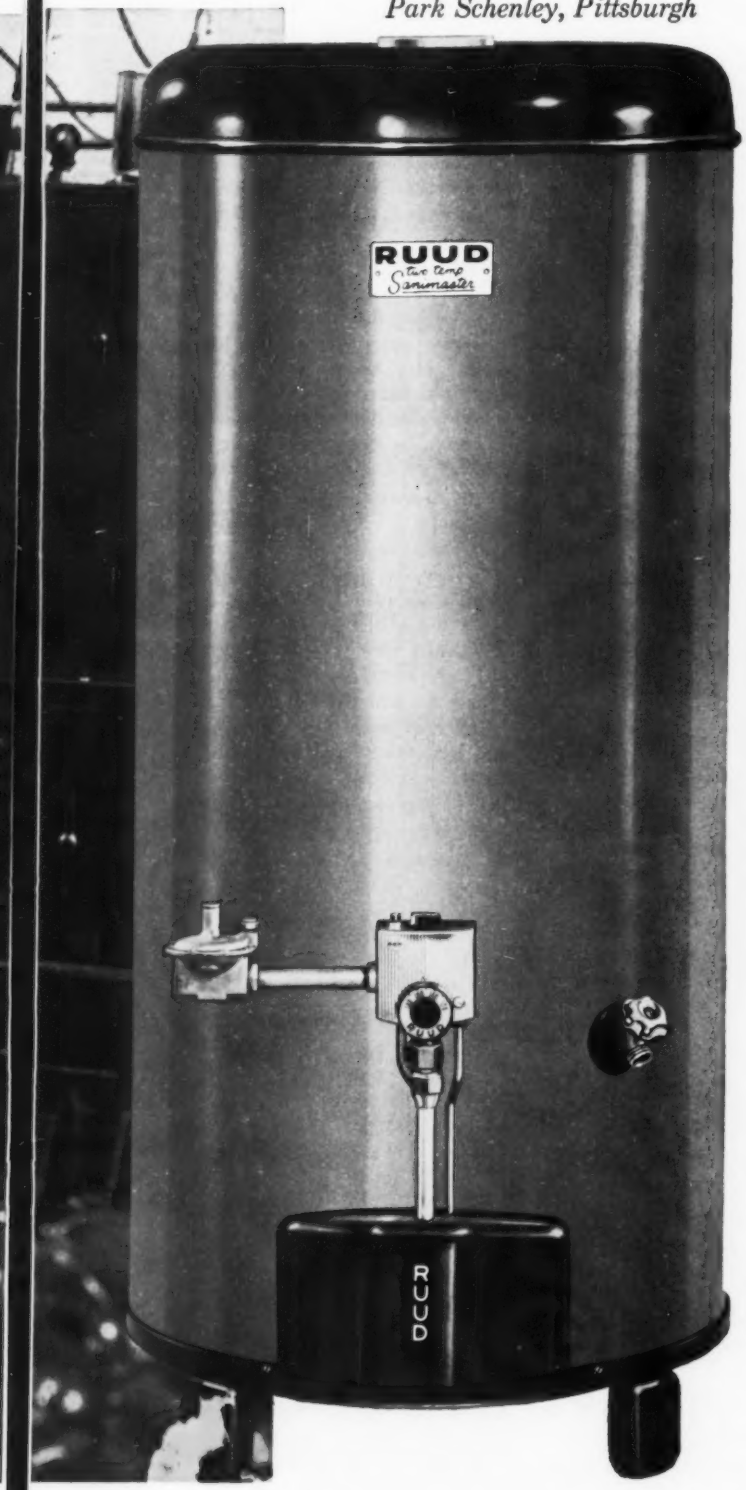

In planning the new Park Schenley in Pittsburgh, manager Frank Blandi realized the importance of a continuous supply of hot water at two different temperatures: 180° sanitizing hot water for dishwashing machines, and regular 140° hot water for general use. With Gas-fired Ruud Sanimasters, he now gets both these needed temperatures *from the same Ruud water heaters at the same time.*

Gas does much more than simplify dishwashing at the Park Schenley. Over 1000 meals are served daily from their modern Gas kitchen. Their Gas-fired food service facilities include—in addition to the 4 Ruud Sanimasters—3 Magic Chef ranges, 2 Magic Chef broilers, a two-compartment Steam Chef, a Groen kettle, a Hobart dishwasher, and a coffee urn.

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Hospitals Report Ownership and Operation of Trucks, Ambulances, Passenger Cars

CHICAGO.—Approximately half the hospitals in a nationwide group participating in a survey own and operate motor vehicles, it was reported here last month.

The survey was conducted by The MODERN HOSPITAL among 223 hospitals of all sizes and types, in all parts of the country. Of this group, 106 hospitals reported that they own and operate their own vehicles.

Of those not owning vehicles, most were in the smaller size groups, and the larger hospitals, such as state hospitals, commonly reported owning several vehicles.

Of 372 vehicles owned by the 106 hospitals, 187 were motor trucks; these were about evenly divided between two classifications, "one ton or smaller," and "over one ton."

There were 88 passenger vehicles in the group, 55 station wagons, and 29 ambulances, it was reported. In addition, the hospitals reported eight "converted ambulances," or modified station wagons or passenger cars; three buses, and two fire trucks.

Thirty-one hospitals in the group were planning to make vehicle purchases at the time they were queried, it turned out. Of these, 20 were planning to purchase passenger automobiles; 17 were going to buy motor trucks; 11, station wagons, and three, ambulances.

Answering a question about ambulance operation, 77 of the hospitals said they would accept and operate an ambulance if it were donated to the hospital by an interested individual or group, in order to expand hospital service. However, 130 hospitals answered that they would be unwilling to operate an ambulance, even if one were donated without charge. Several of these explained that their communities were already adequately served by ambulances operated by the city, fire department, or private owners.

"Ambulance service for our community is rendered by the fire department," one administrator commented. "They have a wonderfully equipped new ambulance, also a rescue and life saving motor transport and a well trained crew."

In some communities, it was reported, ambulance service is provided by undertakers. In these and other cases, the ambulance service was described as adequate, and the hospitals felt no need to offer additional service.

In several cases, the hospitals reported they were operating ambulances which had been donated by service clubs or other groups interested in the hospital.

Nonprofit Hospital Value Estimated at $5 Billion

NEW YORK.—Total value of nonprofit hospital plants and endowments in the United States was estimated at $5,200,000,000 in a report on philanthropy issued by the American Association of Fund-Raising Counsel.

Americans have doubled their annual contributions for philanthropy in the last decade, giving an estimated $6 billion in 1956, according to the report.

In addition, some 35 million volunteers contributed their time and talents to maintenance and operation of philanthropic institutions.

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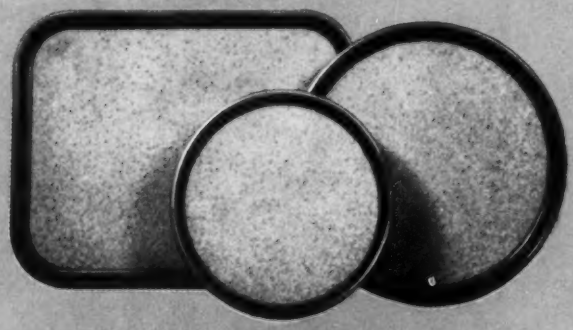

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Washington State Nurses' Group Seeks Collective Bargaining With Hospitals

SEATTLE.—A proposed law that would require hospitals to "bargain in good faith" with nurses and other employes has been introduced in the Washington state legislature.

The measure reflects the principal points of a legislative proposal by the Washington State Nurses Association.

The measure, introduced by three members of the house of representatives, would make it a misdemeanor for any hospital or other "health care activity" to refuse to bargain in good faith with employe representatives on matters of salary and other working conditions.

To engage in certain other specific unfair labor practices also would be a misdemeanor under the proposal.

The bill provides further that if collective bargaining fails to produce an agreement or a satisfactory settlement of differences the dispute can be referred to the state board of labor and industries which can conduct a fact-finding inquiry. The board, after making its inquiry, is called upon to publish its findings in newspapers and to publicize them by radio and television. It is given no legal power to arbitrate or otherwise settle the dispute.

The bill makes no specific mention of nurses, and the machinery as set up applies to all employes. But it was introduced after the nurses' association announced its intention to seek legislation which would provide: a requirement that hospitals engage in collective bargaining with nurses' organizations; that agreements be put in writing, and that unresolved disputes be settled by arbitration.

The W.S.N.A. house of delegates at its 1956 session had instructed its committee to seek legislation "to provide legal protection for the rights of nurses to organize and bargain . . . regarding salaries and other conditions of employment."

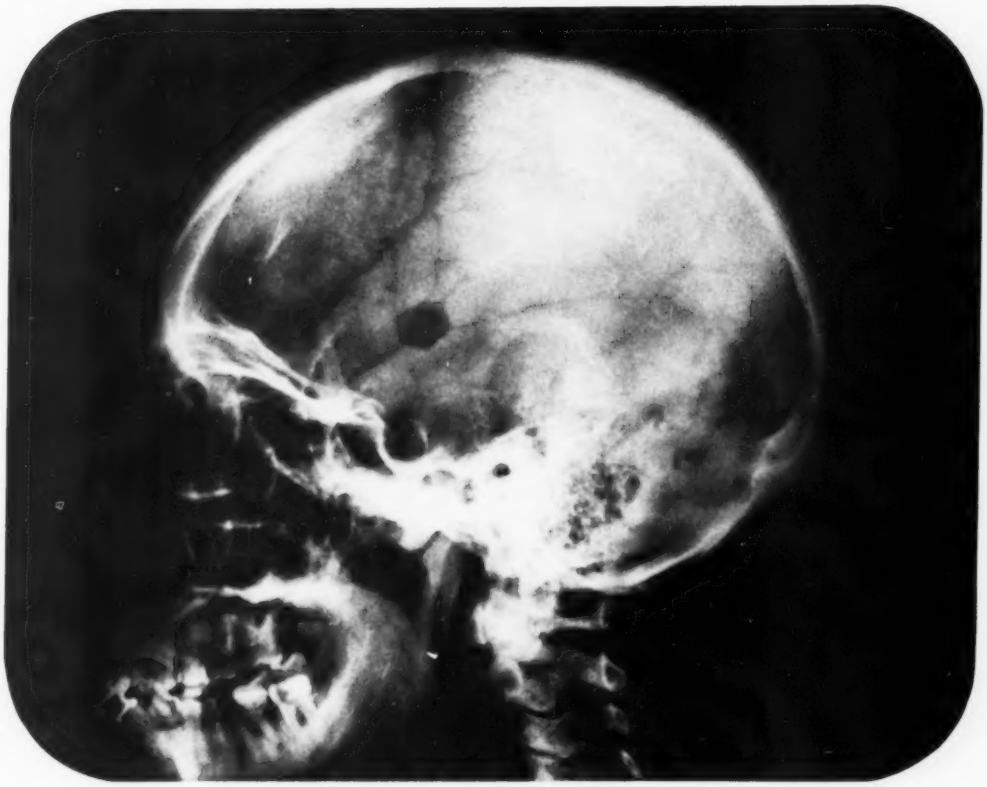
The legal machinery is needed, the association said, because nurses voluntarily have renounced the exercise of their right to strike, and because health care activities (including hospitals, nursing homes and so on) have been reluctant or have refused to negotiate with nurses and to sign collective bargaining agreements with them. This reluctance, the nurses' association said, has the effect of denying nurses rights guaranteed to other employes by federal law and public policy.

John Bigelow, executive secretary of the Washington State Hospital Association, said the hospitals' position would be one of pointing out to legislative committees considering the bill that such state laws are not in effect covering labor relations of other industries or business groups.

Mr. Bigelow said the hospital association has met every year since 1949 with the nurses' association and has made written recommendations to its members concerning salary scales and other working conditions, although it still declines to enter into written labor contracts as such. The association recommendations largely have been followed. The statewide pattern broke down in 1956, and area agreements were made within the state.

Since 1949, base salaries for nurses have increased, under terms of the agreements, from $200 monthly to $285 and $300 monthly. The 40 hour week has been established and sick leave and vacation programs instituted.

$22 Ansco X-ray costs guided this life-saving cost of $1640



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Chicago Hospital Group Elects Delbert L. Price

CHICAGO. — Delbert L. Price, administrator of Children's Memorial Hospital, was named president-elect of the Chicago Hospital Council at the annual meeting here January 23. During the meeting Wendell H. Carlson, administrator of Englewood Hospital, was installed as president, succeeding Arkell B. Cook, administrator of Evanston Hospital, Evanston.

Speaker at the luncheon meeting, attended by 200 delegates, was Ira J. Bach, Chicago Commissioner of City Planning. Mr. Bach discussed "The Effect of Urban Redevelopment on Hospitals" and urged hospital administrators to take an active part in protecting their neighborhoods from the encroachments of slums. He cited the work done by Michael Reese Hospital in developing its master plan as the classic example of what can be done by an institution to rehabilitate a seriously deteriorated area.

A feature of the meeting this year, as it was last, was the presentation of awards of merit in recognition of outstanding services to Chicago area hospitals and the patients they serve. Esther Carlson, supervisor of the maternity department at Swedish Covenant Hospital for 36 years, was selected as the "Hospital Employe of the Year." Voted outstanding "Friend of the Hospital" was Mary Motter, for 14 years a volunteer and senior Gray Lady at Children's Memorial Hospital.

In addition to the two top award winners, three persons received certificates of honorable mention for their services to hospitals. They were Elizabeth Gaskin, a volunteer at Oak Forest Hospital, Oak Forest, Ill.; Elizabeth Kidnay, an employe of Evanston Hospital, Evanston, Ill., and Antonio Fernandez, employe of Presbyterian Hospital. In addition to Mr. Price, officers for the coming year are: vice president, Dr. Karl S. Klicka, director of Presbyterian-St. Luke's Hospital, and secretary-treasurer (reelected), Rev. Joseph A. George, administrator, Evangelical Hospital.

Stanley P. Farwell was reelected chairman of the board of directors. Also elected to the board were Elmer E. Abrahamson, secretary, Norwegian-American Hospital; Ray E. Brown, University of Chicago Clinics; Wendell H. Carlson; Arkell B. Cook; William B. McIlvain, Lake Forest Hospital; Virgil W. Nelson, Lutheran Deaconess Hospital, and Mr. Price.

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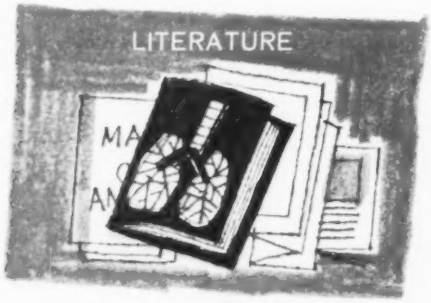
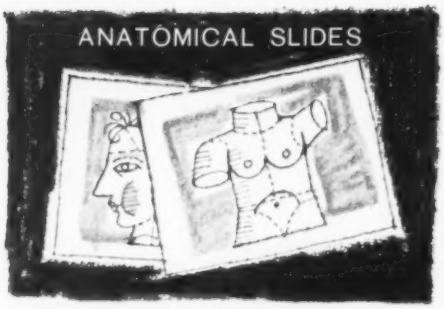
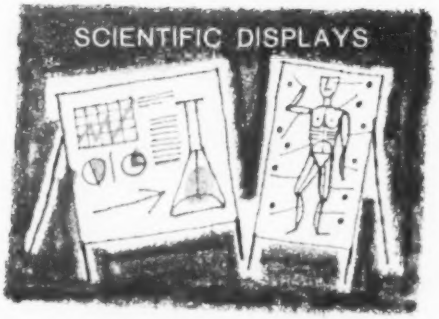


Booklets, brochures and reprints concerning CIBA products will be sent free of charge on request to the Medical Service Department, CIBA, Summit, New Jersey. In addition, three volumes of particular interest from THE CIBA COLLECTION OF MEDICAL ILLUSTRATIONS by Frank H. Netter, M.D.—Vol. 1, *Nervous System** ($7); Vol. 2, *Reproductive System* ($13); and Vol. 3, Part III, *Liver, Biliary Tract and Pancreas* ($10.50)—may be obtained by sending check or money order to Publication Department, CIBA, Summit, New Jersey.

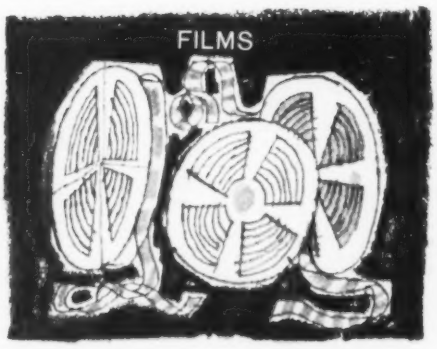
*3rd printing, including Supplement on the Hypothalamus.



An extensive library of colored anatomical slides (art work by Frank H. Netter, M.D.) is available for loan or purchase. A complete list of the slides may be obtained by writing the Publication Department, CIBA, Summit, New Jersey.



The latest scientific information on products manufactured by CIBA is presented in exhibit form for the benefit of staff doctors—without interference with hospital routine. You may write to the Hospital Sales Department, CIBA, Summit, New Jersey, requesting a display on a convenient date.



A library of 16 mm. medical films, some in color, with sound may be borrowed to be used as teaching aids for nurses, residents and internes, or as part of refresher courses and staff meetings. If you wish, projection equipment and a qualified operator will be provided without charge. A list of film titles is available from the Hospital Sales Department, CIBA, Summit, New Jersey.

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1. Eckenhoff, J. E., and Dripps, R. D.: **Anesthesiology**, 15:681, Nov., 1954.

2. Sokoloff, Louis; King, B. D.; and Wechsler, R. L.: **Med. Clin. North America**, 38:499, Mar., 1954.

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Pittsburgh Student Gets A.C.H.A. Scholarship Grant

CHICAGO. — Robert S. Borczon, a student in the graduate program in hospital administration at Pittsburgh University, has been named recipient of the first Mead Johnson grant in the postgraduate training award program of the American College of Hospital Administrators, it was announced at college headquarters here last month.

Mr. Borczon is now serving a second year of residency in hospital administration at Western Pennsylvania Hospital, Pittsburgh. Following academic training at Pittsburgh University, he spent his first year of residency at Hahnemann Hospital, Philadelphia.

Mead Johnson and Company, Evansville, Ind., has provided $2000 annually for the last two years for the postgraduate training award program, the college said.

"Students presently enrolled in an acceptable graduate course program in hospital administration and who are currently in their required residency year, or who are already engaged in an extended residency period, are eligible to apply for the Mead Johnson scholarship," the college said.

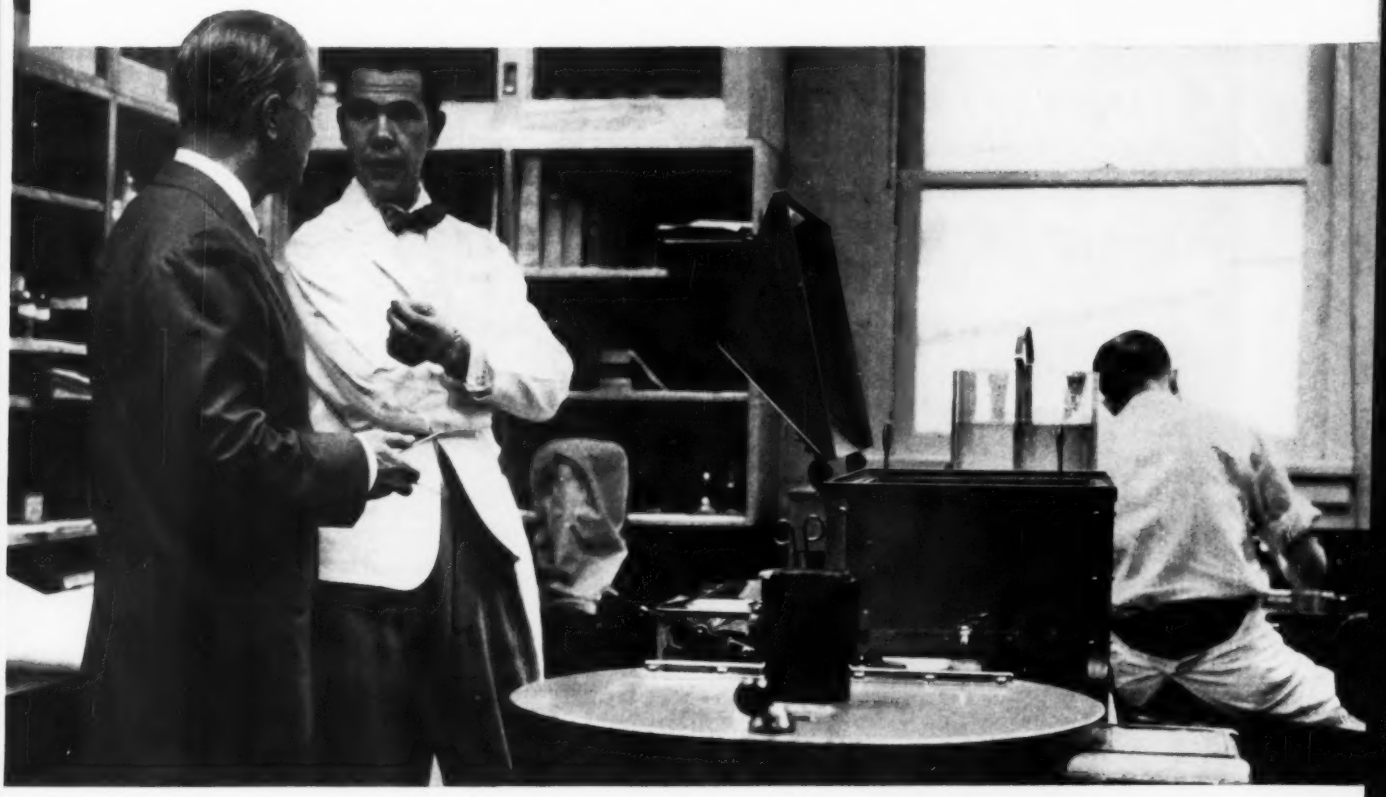
The grant is part of the Mead Johnson program for provision of funds for graduate training in fields allied with medicine, it was explained. "The objective of the program has been to produce better trained individuals to enhance the standards of their respective profession," according to the college announcement.

Consider Merger of Two Blue Cross Plans in Ohio

CLEVELAND.—Merger of the Cleveland and Akron Blue Cross plans is receiving consideration as a measure to improve service to the subscribers of both organizations, it was announced jointly by Ralph S. Schmitt, president of the Cleveland Hospital Service Association, and T. G. Graham, president of Akron Hospital Service.

If put into effect, the consolidation would result in a single Blue Cross organization covering 11 northeastern Ohio counties and serving about 1,725,000 subscribers. Advantages of the merger would include better service to subscribers, improvement in operating procedures, and the elimination of problems caused by overlapping populations and minor variations in subscriber benefits, it was explained.

"Once you've got the facts—expansion comes easy!"



Wasn't long ago that Lab was understaffed and cramped for space. Couldn't seem to cope with the steadily increasing work load. But you'd never know it now. Today, there's a *new* Lab – with greater floor space, adequate equipment, more personnel. And the growing pains of the past are just an unpleasant memory.

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With prompt reports on his desk, the administrator was in a position to analyze the utilization of special services by professional services. And from these figures he was able to ascertain the effect that increased use of new techniques was having on Lab's work load—the trend from BMR to PBI, for instance. Thus informed, he was equipped to make a realistic administrative decision to obtain personnel, increase floor space, purchase equipment.

This is but one example of how proper figure facts can point up situations that demand administrative action. For further evidence, write to us today for your complimentary copy of "Better Patient Care Through Administrative Controls."*

**A paper delivered by John L. Mayer, Jr., at an A.A.H.A. conference, Orlando, Florida*

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A.H.A. Midyear Meeting

(*Continued From Page* 150)

of Greenwich Hospital, Greenwich, Conn., a Blue Cross man from 'way back, came to Mr. Evans' aid. Mutual of Omaha, or any other commercial carrier, he pointed out, would be bound to bend over backward at this stage of the proceedings to make a good impression. It is very much to their interests to do so. None of which, in Mr. Warren's view, changes the fact that Blue Cross is still the hospitals' best bet—and always will be.

The basic question, according to Cleveland Rodgers, executive director of the Oklahoma Blue Cross Plan, is whether Blue Cross is going to become a commercial company or whether it is going to remain free to do a good job. "It is unfortunate that we couldn't settle our differences before Medicare," he lamented. "These same problems are going to come up again with the federal employes and we'd better resolve them quick."

Kenneth Williamson, head of the A.H.A. Washington Service Bureau, reported for his group on the problem of the federal employes health program. He reviewed the two-year battle with the Administration to put the program under Blue Cross and also to have the benefits cover basic hospital expenses instead of major medical, or catastrophic, expenses. Said Mr. Williamson: "The American Hospital Association is deeply interested in the program because if hospitals let major medical expense get by the hospitals would have to pick up the tab for the basic expenses." He reported optimistically that general agreement had been reached by the A.H.A. and the powerful federal employes union on a new bill to be presented this session. Under this plan, federal employes would have their choice of nationwide, 120 day coverage by Blue Cross-Blue Shield, *or* a commercial insurance plan at the national level equal to a service plan, *or* a special federal employes' plan, *or* a group plan like Health Insurance Plan of New York. The choice, Mr. Williamson stated in answer to a question from the floor, would rest with the individual.

The assignment carried by his group, *i.e.* nursing, is "as old as hospitals and rather like having a bear by the tail," Dr. Russell A. Nelson, director of Johns Hopkins Hospital, Baltimore, explained in introducing the official reporter, Stuart W. Knox, executive

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Woman at her Bath.
Marble Statue by
Jean Antoine Houdon.
French, dated 1782

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director of the Connecticut Hospital Association. The consensus of the group, Mr. Knox reported, was that the A.H.A. is doing a good job in helping to solve the nursing problem but "communications are fuzzy." The national association, it is felt, is not letting the state and local associations know precisely what it is doing to relieve the situation at all levels.

The real objective, according to Dr. Dean A. Clark of Massachusetts General Hospital, Boston, is not to train more people badly, but to train more people well. The American Hospital Association, he urged, should define what nursing care is and determine the various levels of nursing. He also recommended that the A.H.A. should attempt to obtain federal aid for nursing education. Since the federal hospitals employ nurses and take them away from voluntary hospitals, he pointed out, it is only fair that the government should make some repayment. The answer from A.H.A. officialdom was that the association has already asked for $5 million.

No burning issues confronted the group assigned to discuss administrative operation of hospitals, according to Dr. James P. Dixon, Philadelphia Commissioner of Public Health, so the delegates talked about relations between the A.H.A. and the states.

Hubert Hughes, administrator of General Rose Memorial Hospital, Denver, reporting for the group, related that the extension of personal membership in the A.H.A. to department heads—beginning with the engineers—is not being looked upon with favor in some states because it creates a conflict of interests. The A.H.A.'s thesis appears to be that "splinter groups" like the engineers', housekeepers', accountants' and pharmacists' associations should be discouraged as far as possible and their members encouraged to participate in the hospital association.

One member rose from the floor to inquire just what value personal membership offers to the individual and also if this measure is not inconsistent with the A.H.A.'s plans to put the institute program back on the state level.

It was explained that the engineers now receive *Hospitals*, a newsletter, packets of manuals and special mailings on subjects of special interest to them. Furthermore, they are made to feel that "they are members of an organization that has their interests at heart."

Speaking for the association, Mary C. Schabinger, Detwiler Memorial Hospital, Wauseon, Ohio, repudiated the suggestion that the association would derive income from the personal memberships. On the contrary, she stated firmly, the association loses money on them.

Tuesday morning's reports created no furor. Some discussion was generated by the report on relationships of hospitals to all types of prepaid hospitalization insurance plans. It centered on whether or not insurance companies should be charged extra for requiring hospitals to fill out special forms instead of using the standard form. Most hospitals, it was revealed, do make such a charge. And in a good many instances, the hospitals simply fill in the standard form and attach the insurance company's form.

The only speakers on the two-day program were Dr. Edward L. Turner, secretary of the American Medical Association's Council on Medical Education and Hospitals, and Dr. Rudolph H. Friedrich, secretary of the Council on Dental Health of the American Dental Association.

Result: A hardy, handsome, all-inclusive place setting to answer every food service need, including economy!

Turning *to* the wonders of electronics helps The Man With the Lily Plan turn *up* novel ideas in paper service design, construction, handling. Here he studies facts and figures showing consumer preferences in kinds of foods and sizes of portions — preferences that will be part of Lily's thinking whenever a new cup, container or plate reaches the blueprint stage.

Probing and investigation of this type are standard operating procedure at Lily*. It leads to innovations like the Lily Place Setting, now meeting with great success in every industry and institutions where complete meals are served. From the perfect-fit tray cover to tiny creamer, Lily created the ideal size and shape cup, container and plate for everything from appetizer to, and through, dessert. Lily created a mood, too, for this is a cheery, bright, matched service that enhances the appeal of food and drink.

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Alabama Hospital Group Elects E. E. Cavaleri Jr.

MONTGOMERY, ALA. — E. E. Cavaleri Jr., administrator of Crippled Children's Clinic and Hospital, Birmingham, was named president-elect of the Alabama Hospital Association, during the association's 36th annual convention here in January. J. Frank Bynum, administrator of Gibson Hospital, Enterprise, took office as president, succeeding Douglas Goode, administrator of Jackson Hospital, Montgomery.

Alabama Hospital Association officers, from left to right: E. E. Cavaleri Jr., president-elect; Douglas Goode, past president; J. Frank Bynum, president; E. C. Bramlett, vice president, and Ernest S. Williams, secretary-treasurer.

Other officers elected were E. C. Bramlett, assistant administrator and business manager of Mobile Infirmary, Mobile, as vice president, and Ernest S. Williams, administrator of Cullman Hospital, Cullman, as secretary-treasurer.

Matthew F. McNulty Jr., administrator, University Hospital and Hillman Clinic, Birmingham, and Ned W. Wickham, administrator, Huntsville Hospital, Huntsville, were elected to three-year terms on the board of trustees. Named to fill two unexpired terms were James W. Brown Jr., administrator, Russel Hospital, Alexander City, and Donald G. Harms, administrator, DeKalb County Hospital, Fort Payne.

Among the convention speakers were Dr. W. Palmer Dearing, deputy surgeon general, U.S. Public Health Service, and Martha Johnson, assistant to the director of the Joint Commission on Accreditation of Hospitals in Chicago.

Allied groups meeting concurrently were the Alabama Hospital Auxiliaries, Alabama Association of Nurse Anesthetists, Alabama Association of Medical Record Librarians, and Society of Alabama Hospital Pharmacists.

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Seven-Up is crystal-clear. No artificial flavor is used.

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If you hanker for a cool, clean taste . . .
If you want a quick, refreshing lift . . .
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Charges Administrators in Adoption Racket

SPRINGFIELD, ILL. — Administrators of two small Chicago hospitals were involved with doctors and lawyers in a "black market" adoption ring in Chicago, Cook County Judge Otto Kerner declared here last month.

The adoption racket was exposed following an investigation in 1955, and the administrators resigned soon afterwards, Judge Kerner said.

He did not identify the administrators or name the hospitals involved.

Judge Kerner spoke at a round table discussion of adoptions during the Illinois Congress on Maternal Care. Fees paid by adopting parents while the ring was active were as high as $6000, Judge Kerner reported. Fees were divided among the doctors, lawyers and hospital administrators.

Unmarried mothers of babies taken for adoption had their hospital bills paid for them, he added, but presumably received no part of the fees.

Judge Kerner described the adoption situation in Chicago as "much improved," though it is still going on "to some extent."

Judge Kerner said 50 per cent of the 3000 adoptions a year handled in his court are within families, with the babies being adopted by relatives. An additional 30 per cent of adoptions are handled by professional child placement agencies, he said.

"It is in the 20 per cent of unsupervised placements that our trouble comes," he concluded.

Obstetricians are subjected to constant pressure by childless couples seeking babies for adoption, a physician member of the panel, Dr. Richard F. Whitlock, Elgin, Ill., said.

A physician's participation in adoption should be limited to informing an adoption agency that a couple is likely to remain childless and is deserving of consideration as adoptive parents, he said.

San Francisco Conference Elects Officers for 1957

SAN FRANCISCO.—Sister Mary Philippa, administrator of St. Mary's Hospital here, was reelected president of the San Francisco Hospital Conference for 1957.

Mark Berke, administrator of Mount Zion Hospital, was elected vice president, and W. P. Geigenmuller, administrator of Stanford University Hospital, was named treasurer.

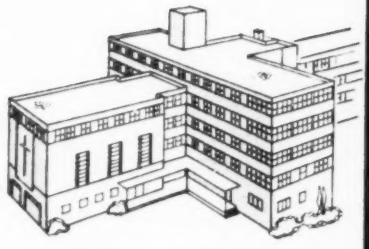
Recent examples of

SUCCESSFUL HOSPITAL CAMPAIGNS

from New England to the Midwest

STAMFORD, CONNECTICUT
St. Joseph's Hospital
Goal: $1,000,000
Pledged: $1,392,280

"The result is truly fabulous."
—The Rev. John P. McNerney, Honorary Chairman

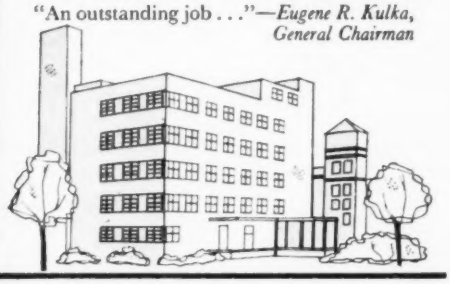


WARREN, OHIO
United Hospital Completion Fund
Goal: $1,000,000 Pledged: $1,246,000

"Never . . . anything so well planned, organized, followed up."
—Wm. A. Sampson, Jr., Co-Chairman

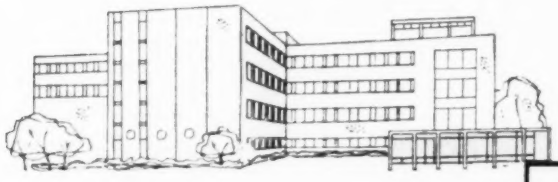
MT. VERNON, N. Y.—Mt. Vernon Hospital
Goal: $250,000 Pledged: $327,000

"An outstanding job . . ."—*Eugene R. Kulka, General Chairman*



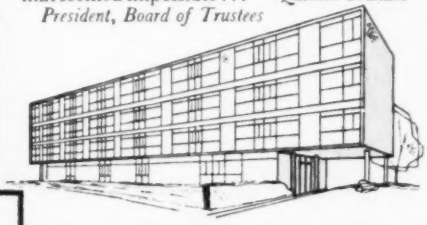
APPLETON, WISCONSIN—Appleton Memorial Hospital
Goal: $1,200,000 Pledged: $1,441,000

"A tremendously successful job."
—Lyman B. Clark, Board of Directors



RIDGWAY, PA.—Elk County Gen. Hospital
Goal: $652,000 Pledged: $740,116

"Still wondering how we reached a goal that seemed impossible . . ."—*Quentin Graham, President, Board of Trustees*



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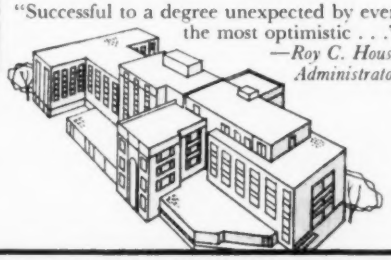
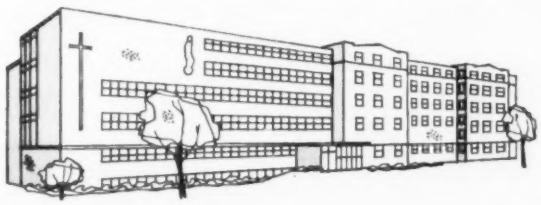
MARION, IND.—Marion General Hospital
Goal: $1,253,000 Pledged: $1,404,000
(Included $253,000 already on hand)

"Successful to a degree unexpected by even the most optimistic . . ."
—Roy C. House, Administrator



JACKSON, MICHIGAN—Mercy Hospital
Goal: $1,250,000 Pledged: $1,370,000

"An outstanding job . . ."—*Donald M. Teer, Special Gifts Chairman*



LOCK HAVEN, PA.—Lock Haven Hospital
Goal: $800,000 Pledged: $968,000

"The Ketchum people left a good feeling behind them in this community . . ."
—Editorial, Lock Haven Express

Student Nurses Learn Geriatric Care Firsthand

NEW YORK.—Seton Hall University College School of Nursing, Newark, N.J., and St. Anselm's College School of Nursing, Manchester, N.H., are making a joint affiliation in geriatrics at Mary Manning Walsh Home here. Eighteen fourth-year students visited the home for the aged to observe the specialized care given the geriatric patient.

"Just as it has been customary for student nurses to spend a period of time in psychiatric and communicable disease affiliation," the home said, "it is now being recognized that an opportunity for experience in geriatric and gerontological services would be valuable and meaningful and would prove a real asset."

Name Change Announced

PITTSBURGH.—A change in the name of the Hospital Service Association of Pittsburgh to the "Hospital Service Association of Western Pennsylvania" was announced by William H. Ford, president of the local Blue Cross plan for hospital care.

M.D.'s Answer Critics at A.M.A. Congress on Medical Education

(*Continued From Page* 150)

cultural interests or a compassionate response to the human needs of patients.

Emphasis on scientific training is essential in medical education, Dr. Atchley said, and scientific medicine is the best protection the public has against quackery. It is not true, as some have claimed, that "scientific training dries up the milk of human kindness," Dr. Atchley asserted.

Dr. Atchley also warned against current attacks on the full-time clinical teacher. The greatest strides in the advance of scientific medicine were made following the appointment of full-time clinical faculties, he pointed out.

The pressure to train more and more general practitioners is a threat to science, Dr. Atchley warned. The development of medical "jacks-of-all-trades" would relegate medical schools to trade school status, he said.

Speaking at another session, Dr. Edward L. Turner, secretary of the council, deplored the effort of some groups to impress the public that "only general practitioners are qualified to understand people."

"Such misrepresentations of fact are not in the best interest of the public or the medical profession, even though they make good stories for the press," Dr. Turner declared. "We are all physicians first, interested in the improvement of medical education and medical care."

Dr. W. Barry Wood Jr., vice president of the Johns Hopkins medical institutions, Baltimore, described a Johns Hopkins study of medical education aimed at shortening the span of the educational program and adding basic strength in the science departments.

As the depth and breadth of medical knowledge has increased, the educational period has become longer and longer, Dr. Wood said. "This demanding period of training with its inevitable economic strain has become so long that it is beginning to discourage candidates from entering the field of medicine," he explained.

A committee representing the medical school and other university disciplines is working jointly at Johns Hopkins to attack this problem, he reported.

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Mobile Toastmaster Hot-Food Servers with precisely controlled temperature and humidity protect food for hours!

How pleased your patients will be when *every* meal arrives piping-hot and fresh! *You'll* be pleased, too, when you add up the savings in food, time and labor!

More and more leading hospitals are finding that mobile Toastmaster Hot-Food Servers provide the utmost in quality and portion control. Complete plates of hot food can now be assembled in the central kitchen—under the supervision of the dietitian—loaded into the convenient Hot-Food Server drawers, and wheeled to the floors for easy serving. This efficient food service assures hot meals that are oven-fresh in flavor and appearance. It also eliminates call backs, and provides an accurate count of hospital meals. And equally important—only the amount of food that is to be served is prepared, thus reducing waste!

A unique system of six-sided air circulation and adjustable humidity controls for each drawer, plus an exacting Robertshaw thermostat, keeps crisp foods crisp and moist foods soft. Gleaming stainless-steel exteriors and drawers, for complete sanitation. No installation expense—operates on any standard 115-volt circuit.

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Model 3D2-C 4-drawer mobile $560.00†
Holds 32 plates of hot food.

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†Prices slightly higher in Pacific Coast states.

Holds food for busy people while doctors or nurses are in emergency.

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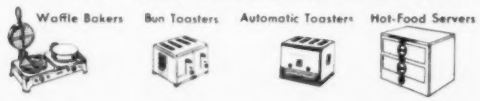

COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Schroeder Hotel, Milwaukee, Oct. 7-10.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Atlantic City, N.J., Sept. 28-30.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Regional Membership Conferences: Region 15, Vancouver, B.C., March 4-8; Region 9, Chicago, March 11-15; Region 13, Berkeley, Calif., June 10-14; Region 12, Houston, Tex., July or August.

AMERICAN COLLEGE OF OSTEOPATHIC HOSPITAL ADMINISTRATORS, St. Louis, Oct. 26.

AMERICAN HOSPITAL ASSOCIATION, national convention, Convention Hall, Atlantic City, N.J., Sept. 30-Oct. 3.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, St. Louis, Oct. 27-30.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Palmer House, Chicago, June 22-29.

AMERICAN SOCIETY OF X-RAY TECHNICIANS, international convention, Sheraton Park Hotel, Washington, D.C., June 8-13.

ARKANSAS HOSPITAL ASSOCIATION, Marion Hotel, Little Rock, May 23-25.

ASSOCIATION OF WESTERN HOSPITALS, Statler Hotel, Los Angeles, May 6-9.

BRITISH COLUMBIA HOSPITALS' ASSOCIATION, Vancouver Hotel, Vancouver, Oct. 15-18.

CALIFORNIA HOSPITAL ASSOCIATION, Lafayette Hotel, Long Beach, Oct. 30-Nov. 1.

CANADIAN HOSPITAL ASSOCIATION, Bessborough Hotel, Saskatoon, Sask., May 27-29.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 4, 5.

CATHOLIC HOSPITAL ASSOCIATION, Statler Hotel, Cleveland, May 27-30.

CONNECTICUT HOSPITAL ASSOCIATION, Conn. Light & Power Co., Berlin, Conn., Nov. 13.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Hotel Claridge, Atlantic City, N.J., May 22-24.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Convention Hall, Atlantic City, N.J., May 22-24.

INDIANA HOSPITAL ASSOCIATION, Student Union, Univ. of Ind. Medical Center Campus, Indianapolis, Oct. 9, 10.

IOWA HOSPITAL ASSOCIATION, Hotel Savery, Des Moines, Apr. 25, 26.

KANSAS HOSPITAL ASSOCIATION, Broadview Hotel, Wichita, Nov. 14, 15.

KENTUCKY HOSPITAL ASSOCIATION, Phoenix Hotel, Lexington, Mar. 26-28.

LOUISIANA HOSPITAL ASSOCIATION, Captain Shreve Hotel, Shreveport, Mar. 28-30.

MAINE HOSPITAL ASSOCIATION, Samoset Hotel, Rockland, June 11, 12.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D.C., Nov. 6-8.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, May 9.

MICHIGAN HOSPITAL ASSOCIATION, Grand Hotel, Mackinac Island, June 21, 22.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 22-24.

MID-WEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, Mo., April 24-26.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION, Ambassador Hotel, Atlantic City, N.J., April 29-May 3.

NATIONAL GERIATRICS SOCIETY, Hotel Statler, Washington, D.C., June 11-13.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Oct. 17, 18.

NEW ENGLAND HOSPITAL ASSEMBLY, Statler Hotel, Boston, Mar. 25-27.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 22-24.

NEW MEXICO HOSPITAL ASSOCIATION, Hilton Hotel, Albuquerque, Mar. 11-13.

NEW YORK STATE DIETETIC ASSOCIATION, Hotel Utica, Utica, N.Y., May 2, 3.

NORTH DAKOTA HOSPITAL ASSOCIATION, Dacotah Hotel, Grand Forks, April 23, 24.

OHIO HOSPITAL ASSOCIATION, Hotel Cleveland, Cleveland, Mar. 31-April 4.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 28-30.

SOUTH DAKOTA HOSPITAL ASSOCIATION, spring conference, Marvin Hughitt Hotel, Huron, April 15, 16; fall meeting, Sheraton Cataract Hotel, Sioux Falls, Oct. 15, 16.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta Biltmore Hotel, Atlanta, Ga., April 24-26.

TENNESSEE HOSPITAL ASSOCIATION, Mountain View Hotel, Gatlinburg, May 30-June 1.

TEXAS HOSPITAL ASSOCIATION, Shamrock-Hilton Hotel, Houston, May 14-16.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 29-May 2.

UPPER MIDWEST HOSPITAL CONFERENCE, Auditorium, Minneapolis, May 22-24.

VERMONT HOSPITAL ASSOCIATION, Long Trail Lodge, Pico Peak, Rutland, Oct. 18.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Chamberlin, Old Point Comfort, Nov. 15, 16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Greenbrier Hotel, White Sulphur Springs, Aug. 1-3.

WISCONSIN HOSPITAL ASSOCIATION, Hotel Schroeder, Milwaukee, March 17.

Recovery Rooms Offer Safer and Better Care, Surgeons, Nurses Agree

(*Continued From Page 54*)

needs of these patients are such that all visitors are excluded, with the exception of a family member in extreme circumstances.

9. Must radium implant cases be isolated, if they are brought to the recovery room?

The patients may be handled the same as other recovery room patients, with necessary precautions to protect staff members, as in other radium plant cases.

10. Should there be a special charge for recovery room service?

Raymond C. Wilson, administrator of Southern Baptist Hospital, New Orleans, said the charge was customary but the amount varied with the individual hospital. Dr. Ochsner disagreed, stating that recovery room service is a necessity for which no extra charge should be made.

In another joint session of surgeons and nurses, on thoracic surgery, the treatment of cardiac arrest was discussed in detail, with several authorities emphasizing the need for close teamwork and awareness of what has to be done, and the importance of having necessary equipment and supplies readily accessible at all times.

New QUIET for Hospital Quiet-Zone

When quiet prevails in a hospital, everyone benefits. In many of the country's hospitals, such as the Indianapolis Community Hospital, sound-absorbing ceilings of Acousti-Celotex Tile bring *quiet comfort* to all areas . . . speeding patient convalescence, raising personnel efficiency and morale. Acousti-Celotex Sound Conditioning checks noise effectively in corridors, lobbies, kitchens, utility rooms, wards, nurseries, operating and delivery rooms. **Mail Coupon Today** for a *free analysis* of the noise problem in your hospital, plus free booklet.

Delivery room of the Indianapolis Community Hospital, Indianapolis, Indiana, showing ceiling of Acousti-Celotex Random* Pattern Perforated Mineral Fiber Sound Conditioning Tile. Architect: Daggett, Naegele & Daggett. Acousti-Celotex Contractor: Hugh J. Baker & Co.

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Canadian Judge Cited

CHICAGO. — Judge John Milton George of Morden, Manit, received a citation of accomplishment from the American Hospital Association at a dinner here in December marking the end of his term as a commissioner of the Joint Commission on Accreditation of Hospitals.

ABOUT PEOPLE

(*Continued From Page* 88)

John R. Cartmell

John R. Cartmell has been named administrator of Suburban Community Hospital, now under construction at Cleveland. Mr. Cartmell received his training in hospital administration at the Memorial Center for Cancer and Allied Diseases, New York. For the last four years he has been assistant administrator of Highland View Hospital, Cleveland.

Preston Williams has been appointed administrator of the Robberson-Shirley Hospital, Wynnewood, Okla., replacing **S. N. Barrett,** who resigned to go into private business.

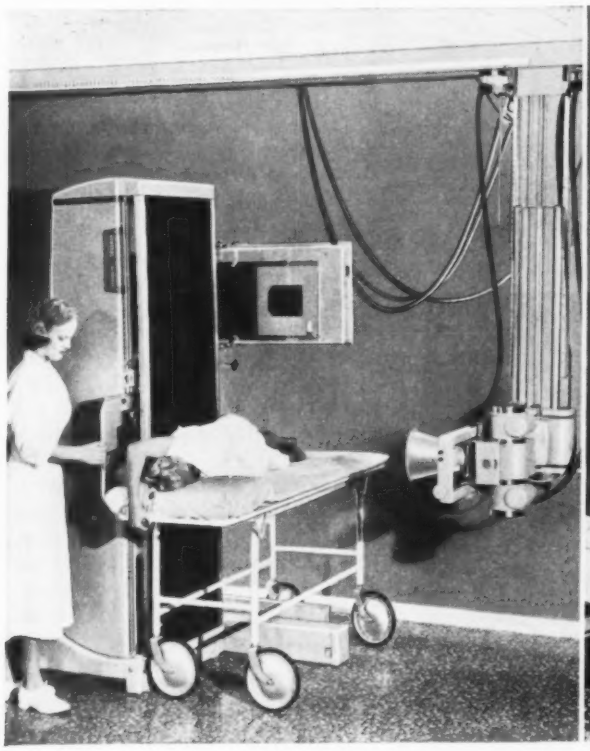
Dr. Frederick W. LaCava, former director of laboratories for the General Hospital of the Greater Miami area, has been appointed administrator of the Monroe-Jackson Hospital, Hollywood, Fla.

Harold M. Salkind

Harold M. Salkind has been named administrative director of Trafalgar Hospital, New York. The hospital took over operation of the general hospital facility vacated by Beth David Hospital in September 1956. Mr. Salkind, who has been in the New York hospital field for 30 years, held the position of director at Beth David Hospital for 16 years. He is a member of the American College of Hospital Administrators and the American Hospital Association.

Martha C. Lockman, formerly administrator of New York Infirmary, New York, has been appointed assist-

ARISTOCRAT / *a new G-E diagnostic unit in step with your progress*



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NOW—better x-ray facilities for less investment

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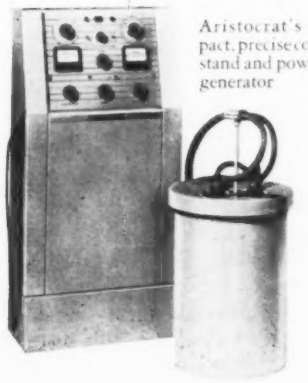

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HERE'S the type of purchase that cost-conscious hospital administrators appreciate: Maximum return per dollar invested . . . maximum utility per square foot of room space.

The General Electric Aristocrat offers advanced features radiologists want—in a complete, compact package . . . at a price that spells significant savings.

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- **choice of tube stands** — conventional upright mountings or the newer ceiling-mounted type

This advance in x-ray economics is just what you'd expect from General Electric. It's the result of cost-conscious engineering and modern assembly-line manufacturing methods.

Remember, too, when you work with General Electric, you achieve security as well as economy—one responsible source for planning, financing, installation and service. Ask your G-E x-ray representative to show you how the Aristocrat gives you more for your x-ray dollar. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, for your copy of Pub. H-31.

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ant administrator of Children's Hospital, Detroit.


Samuel Davis

Samuel Davis has been appointed administrative assistant and director of outpatient services at Roosevelt Hospital, New York. Mr. Davis has held several positions at the hospital, including that of administrative resident to fulfill a requirement for his master's degree in hospital administration from Columbia University's school of public health. He will succeed **Alvin J. Conway,** whose appointment as assistant executive director of Knickerbocker Hospital, New York, was announced in these columns in the February issue of The Modern Hospital.

Richard Wittrup has been named administrator of the University Hospital, Lexington, Ky. He formerly was administrative assistant of the University of Chicago clinics and at the same time held the position of assistant director of the university's program in hospital administration.


Marcus E. Drewa

Marcus E. Drewa has been named administrative assistant at Southern Baptist Hospital, New Orleans. He is a graduate of Northwestern University's course in hospital administration and will receive his master's degree in June. Mr. Drewa worked at the Medical Center Hospital, Tyler, Tex., prior to enrolling at Northwestern.

Dr. Paul L. Eisele, manager of the Veterans Administration hospital, Waukesha, Wis., has been appointed manager of the V.A. hospital, Albuquerque, N.M. A veteran of World War II with the rank of lieutenant-colonel, Dr. Eisele has been with the V.A. since 1947. He will succeed **David K. Dalager,** who is retiring.

Robert C. Couch has been named administrator of Cherokee County Hospital, now under construction at Centre, Ala. A graduate of Auburn and the University of Georgia's school of hospital administration, Mr. Couch formerly was assistant administrator of the Hamilton Memorial Hospital, Dalton, Ga.

Dr. Earl C. Gluckman, director of professional services at the V.A. hospital in the Bronx, N.Y., has been appointed manager of the V.A. hospital, Coral Gables, Fla., succeeding **Dr. Harold F. Machlan,** who is retiring. At the same time, the Veterans Administration announced that **David Anton** has been named manager of the V.A. tuberculosis hospital at Castle Point, N.Y. He formerly was assistant manager of the Manhattan V.A. hospital, New York City.

Drexel Toland has been moved from the position of administrative assistant to that of assistant administrator at Baptist Memorial Hospital, Memphis, Tenn. Mr. Toland is a graduate of the hospital administration program at Northwestern University.


Fred J. Stonage

Fred J. Stonage has been appointed administrator of the Bixby Knolls General Hospital, Long Beach, Calif. He formerly was associated with the Hawthorne Community Hospital, Hawthorne, Calif. Mr. Stonage received his master's degree in hospital administration from St. Louis University.

The Rockette bassinet is of seamless, stainless steel—easily cleaned and sterilized. Full-length piano hinge gives sturdy support to the metal-bound, shatterproof glass lid.

Comfortable working height of the Rockette facilitates care, and safety glass lid permits observation of visceral excursions and changes of skin color during treatment of neonatal asphyxia.

IN NEONATAL ASPHYXIA:

Natural, non-traumatic resuscitation

Rocking provides gentle, non-traumatic activation of the inert diaphragm through alternate excursions of the viscera. Rocking likewise gently stimulates circulation, aids oxygenation of the vital higher centers, until normal respiration is established.

The ROCKETTE® is the only commercially-available, fully automatic rocking bassinet. Explosion proof,* simple to operate, and ruggedly built, the ROCKETTE requires no attention while in operation, and minimal maintenance. Both the angle and the rate of rocking are easily adjustable.

"Since," as Millen[1] states, "the most effective aid to respiration must help both circulation and ventilation and . . . ventilation has both an inspiration and expiration phase,[2] . . . Eve's rocking method of resuscitation will do all this."[3] Applying this principle by means of the ROCKETTE, Millen et al.[4] tell how this method reversed cyanosis and maintained respiration in newborn infants observed during an eight-year period.

The ROCKETTE rocking resuscitator may be purchased with the understanding that if it does not meet with your full approval, it may be returned for full credit. To obtain 8-10 minute ROCKETTE film, or to place your return-privilege order, phone us collect (OSborne 5-5200, Hatboro, Pa.)

*Listed by Underwriters' Laboratories for use in hazardous locations.

References: (1) Millen, R. S.: N.Y. State J. Med. 55:779, 1955.
(2) Karpovitch, P.: Adventures in Artificial Respiration, New York, Associated Press, 1953.
(3) Eve, F. C.: Lancet 2:995 (1932); Eve, F. C., and Forsyth, N. C.: Brit. M. J. 2:554 (1948).
(4) Millen, R. S., Rowsom, A. F., and Mayberger, H. W.: Am. J. Obs. & Gyn. 70:1087, 1955.

for simple, non-traumatic management of neonatal asphyxia

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An ingenious vaporizer-aspirator assembly provides the Rockette with a steady flow of humidified oxygen, with mild suction available for aspiration during rocking.

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**Trademark*

Sister Anna Cecilia has been named administrator of St. Joseph Hospital and Medical Center, Hancock, Mich. At the same time the hospital announced that **Sister Mary Julia** was named as assistant administrator and **Sister Annetta Clare** as director of nurses.

Dr. Ellsworth R. Browneller has been named acting medical director of Jefferson Medical College Hospital, Philadelphia, following the death of **Dr. Hayward R. Hamrick** (reported elsewhere in these columns). A graduate of Columbia University's program in administrative medicine, Dr. Browneller previously held the position of assistant to the medical director at Jefferson. He is a member of both the American Hospital Association and the American Medical Association, as well as the American Public Health Association.

Gerald R. Lorenz has been named administrator of Milford Memorial Hospital, Milford, Del., following the death of **Charles E. Varney.** Mr. Lorenz formerly was assistant managing director and controller of Memorial Hospital, Wilmington, Del.

Dr. Henry Luidens of the Veterans Administration will become superintendent of the Lima State Hospital, Lima, Ohio, effective April 1. He will succeed **Dr. Roy E. Bushong,** who has been with the Ohio mental hygiene system for 45 years.

Jack Hensley, administrator of Asbury Hospital, Salina, Kan., has resigned after seven years at the hospital.

Albert W. Mayer has been appointed administrator of Titusville Hospital, Titusville, Pa., succeeding **Mildred N. Watcher,** who is resigning after 20 years at the Titusville hospital. Mr. Mayer formerly was assistant superintendent of Conemaugh Valley Memorial Hospital, Johnstown, Pa.

Dr. Marc H. Hollender, professor and chairman of the department of psychiatry of the State University College of Medicine, Syracuse, N.Y., has been named director of Syracuse Psychopathic Hospital. He succeeds **Dr. Richard F. Binzley,** former director, who has been serving as acting director since 1954. Dr. Hollender also is a consultant to the Veterans Administration hospital at Syracuse and will continue in his present capacity at the College of Medicine. A graduate of the University of Illinois College of Medicine, Dr. Hollender is a fellow of the American Psychiatric Association, and a member of the American Psychosomatic Society, Inc., the American Psychoanalytic Association, and the American Medical Writers Association.

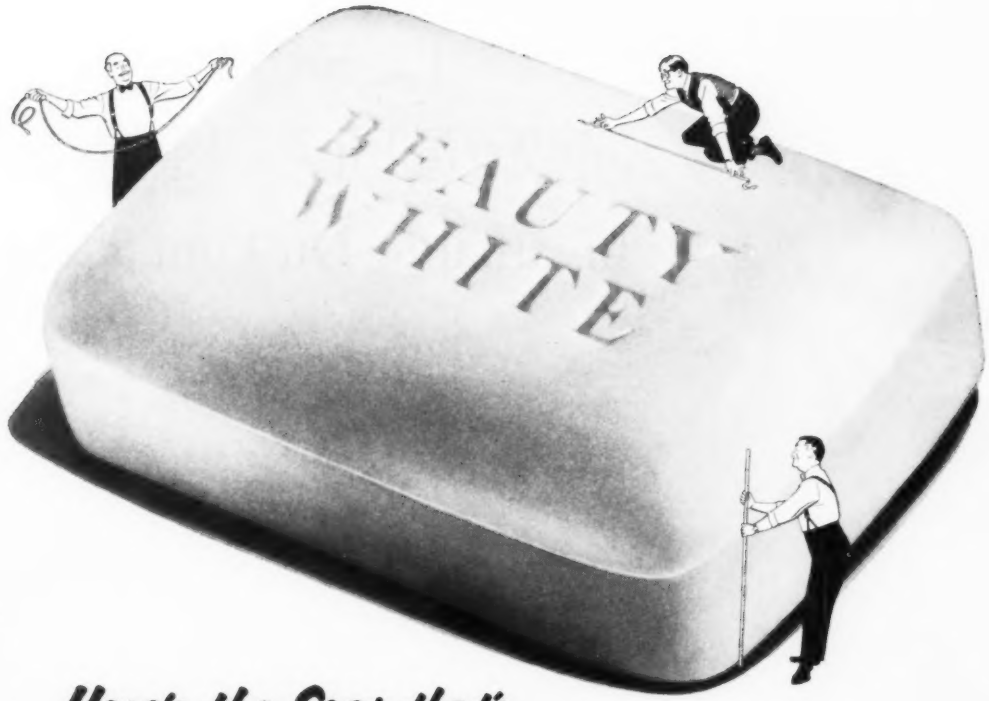
Robert Garrison has been named administrator of People's Hospital, Independence, Iowa. **Mary Aliano,** who has been acting administrator, will remain at the hospital in charge of nursing and surgery.

Robert L. Ehrman, administrator at Junction City Municipal Hospital, Junction City, Kan., has resigned.

Welch England has been appointed administrator of Hershey Hospital, Hershey, Pa. He formerly was administrative assistant at Harrisburg Polyclinic Hospital, Harrisburg, Pa.

Department Heads

Norma E. Coggan has been named to the newly created post of director of nursing at Pennsylvania Hospital, Department for Mental and Nervous Diseases, Philadelphia. The position combines the men's and women's divisions which previously had been separate functions, directed by **Letitia Wilson** and **LeRoy N. Craig,** both of whom recently retired. Miss Coggan formerly served at the Massachusetts Mental



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Health Center, Boston. She received her graduate degree from Yale University School of Nursing.

Melvin J. Slade has been appointed controller of Knickerbocker Hospital, New York. A member of the New York Bar, Mr. Slade is a graduate of New York City College and Brooklyn Law School. He formerly was associated with an accounting firm.


L. Russell Jordan

L. Russell Jordan has been named director of Duke University's outpatient department and assistant professor of hospital administration. Formerly business manager of the medical outpatient clinics at Duke, Mr. Jordan will head administrative reorganization of the entire outpatient department in preparation for moving into the hospital's new addition this spring.

Clifford I. Argall has joined the staff of Baptist Memorial Hospital, Memphis, Tenn., as director of the blood bank. Mr. Argall formerly was director of the research division of the bureau of laboratories for the Utah State Department of Health, where he established a blood grouping program on a statewide basis.


Dr. Ben L. Boynton

Dr. Ben L. Boynton has been appointed director of physical medicine and rehabilitation for Oak Forest Institutions, part of Cook County Institutions, Chicago. He also will be associated with the direction of physical medicine at Cook County Hospital. Dr. Boynton previously was medical director of the Rehabilitation Institute of Chicago. He will retain the chairmanship of physical medicine and his status as a professor at Northwestern University Medical School.

Henrietta E. Davis has been named the first director of nursing for the Board of Hospitals and Homes of the Methodist Church, Chicago. Miss Davis, who has been associate director of education at Presbyterian Hospital, Chicago, will work in an advisory capacity with administrators and directors of Methodist hospital schools.

Miscellaneous

Judith Gage Whitaker will become executive secretary of the American

Nurses Association, effective in June 1958. She will succeed **Ella Best,** who will retire in 1958 after 27 years with A.N.A., the last 10 as executive secretary. Mrs. Whitaker is now A.N.A. deputy executive secretary and a consultant to the army nurse corps. She is a graduate of Nebraska Methodist School of Nursing, Omaha, and was the first student to receive a master's degree in administration of nursing organization from Teachers College, Columbia University.

George W. Brooks has been named research assistant for the Hospital Council of Western Pennsylvania, to direct a hospital information survey for the council. He has been associated with the Hospital Council of Greater New York.

Margaret Virginia Bounds, chief of the dietetic service at the Veterans Administration hospital, Martinsburg, W.Va., has been appointed dietetic specialist in administration at the V.A. central office, Washington, D.C.

Dr. Robert H. Hamlin has been named to the newly created position of special assistant for program planning to the Secretary of Health, Education and Welfare. His post entails the long-term development of federal policy in such areas as social security, vocational rehabilitation, and medical assistance for the needy. Dr. Hamlin formerly was a lecturer on public health law at the Harvard School of Public Health and assistant professor of legal medicine at the Harvard Law School, and is a graduate of both institutions. He also is a graduate of Northwestern University Medical School.


Harold G. Pearce

Harold G. Pearce has been named a vice president of the Blue Cross Association. Mr. Pearce will take a temporary leave of absence from his post as enrollment director of the Michigan Hospital Service to head the national sales activity of the association. A member of the American Hospital Association and the Michigan Hospital Association, he has been associated with Michigan's Blue Cross plan for the last 12 years.

Viola Bredenberg has joined the staff of the Catholic Hospital Association of the United States and Canada as secretary of the association's council on nursing service. Miss Bredenberg recently completed six years of army service. Previously she had been a clinical instructor at the University of Michigan School of Nursing and an assistant professor at the Catholic University School of Nursing Education, where she received her master's degree in nursing. Miss Bredenberg is the author of "Nursing Service Research."

Deaths

Dr. Hayward R. Hamrick, vice president and medical director of Jefferson Hospital and secretary of the board of trustees of Jefferson Medical College and Hospital, Philadelphia, died January 22 of a pulmonary embolism at the age of 49. During Dr. Hamrick's administrative period the Jefferson Medical College and Hospital had expanded to include other hospitals and institutions and formed affiliations to become the Jefferson Medical Center. Dr. Hamrick was active in the American College of Hospital Administrators, the Alpha Kappa Kappa medical fraternity, the Philadelphia County Medical Society, the American Hospital Association, and other medical and social societies, as well as civic agencies and community medical affairs.

This sound-absorbing ceiling of Armstrong Arrestone conforms with the rigid sanitary standards for the delivery room of the Muhlenberg Hospital, Plainfield, New Jersey. Architects were Ferrenz & Taylor; Acoustical contractor, Wm. J. Scully Acoustics Corp.

CAN A SOUND-ABSORBING CEILING COMPLY WITH STRICT SANITARY REQUIREMENTS?

The ceiling in the delivery room of this modern hospital is Armstrong Arrestone, a highly efficient acoustical material that absorbs up to 85% of the room noise that strikes its surface.

Armstrong Arrestone was specified not only for its excellent sound-conditioning qualities, but also because it conforms with strict sanitary standards.

Arrestone is a metal-pan type material backed up with a mineral wool pad. Its smooth white, baked-on enamel finish is easy to keep clean. And it reflects 75% of the light that strikes it without causing annoying glare.

Rated incombustible, Arrestone meets all fire-safety regulations which call for an incombustible acoustical material.

Installation time is fast, and individual units of an Arrestone ceiling can be easily removed and replaced at any time to speed repairs on concealed wiring, pipes, or ducts.

Call your Armstrong Acoustical Contractor for a free estimate on Arrestone or any of the complete line of Armstrong Acoustical Materials. You'll find him listed in the Yellow Pages of the phone directory.

A new booklet, "Quiet at Work," describes how sound conditioning can work for you. For your free copy, write to Armstrong Cork Company, 4203 Union St., Lancaster, Pa.

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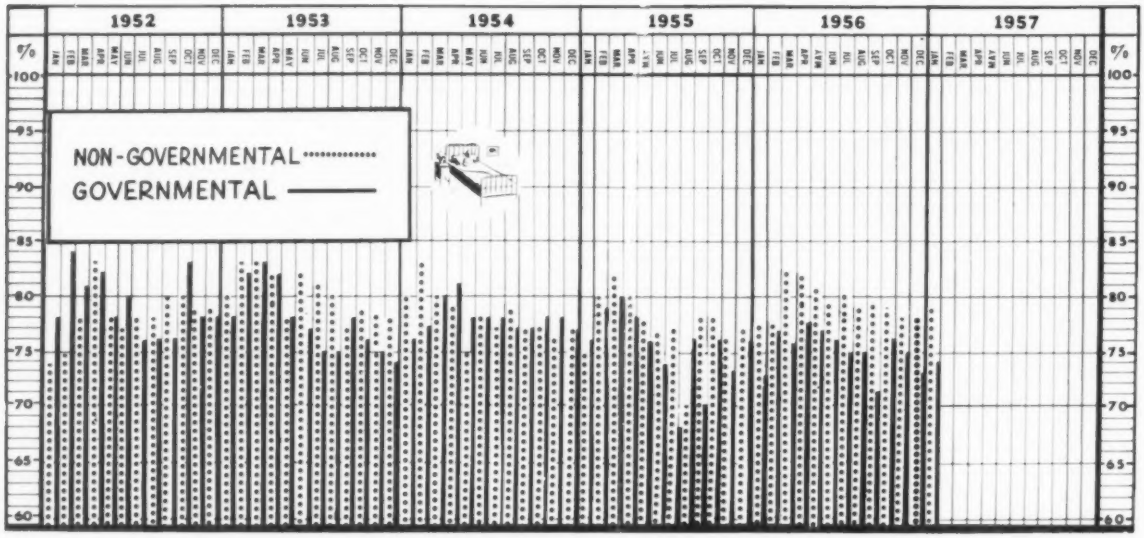
Construction for Year to Date Totals $80,119,160



For the month of January, government hospitals reported occupancy at 73.9 per cent of capacity—down 3.2 per cent from their report of January 1956. Voluntary hospital reports to the Occupancy Chart show January occupancy at 79.4 per cent of capacity—about level with January 1956.

Hospital construction from January 21 through February 4 totaled $35,677,620, bringing the total for the year thus far to $80,119,160. For the similar period of 1956, building projects amounted to $38,564,210, and the total for the year to $60,119,160.

Of the 51 current projects, 17 are hospitals and 29 are additions to existing facilities.

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POSITIONS WANTED

ADMINISTRATOR—8 years, 250-bed general hospital; chief accountant, administrative assistant, 4 years assistant; experience includes planning, equipping, staffing new hospital; NACHA-34. Apply MW 129, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ADMINISTRATOR—5 years, 50-bed accredited hospital; course graduate; seeks administrative position in 200-800 bed hospital; Atlantic Coast. Reply MW 135, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ADMINISTRATOR OR ASSISTANT—Well qualified, trained, experienced; young; excellent references; proven managerial acumen; Massachusetts prefered. For resume write MW 133, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST—Male, M.D.; many years experience in all phases of anesthesia; available immediately; salary or fees. Apply MW 131, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

LIBRARIAN—Medical Record; eligible for registration; 6 years hospital experience, office manager, MRL; seeks assistanship to RRL in approved hospital New England. Reply MW 134, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

FELLOW AMERICAN COLLEGE HOSPITAL ADMINISTRATORS; now employed, internationally known, wide experience in hospital surveys, planning, construction, equipment, organization, administration, seeks new position, Central or South America; outstanding qualifications; speaks fluent Spanish; available October. Apply MW 136, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

OUR 60th YEAR

WOODWARD

Medical Personnel Bureau

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3rd floor • 185 N. WABASH AVE.

CHICAGO • 1

• ANN WOODWARD • *Director*

ADMINISTRATOR—BA, M.H.A.; 3 years, administrator, 250-bed general hospital; late 30's; member, ACHA.

ADMINISTRATOR—7 years, assistant administrator, large teaching hospital; now seeks, and ready for greater responsibility; nominee, ACHA.

ADMINISTRATOR—6 years, 5 years, administrator, hospitals, 200, 300-beds respectively; achieved great success both posts; seeks larger hospitals; membe ACHA.

ADMINISTR/ OR—RN; good experience, all levels nursing, years, director, 60-bed hospital; now prefers midwest; member ACHA.

ADMINISTRATIVE ASSISTANT—M.H.A.; 2 years, administrative residency; 4 years, hospital experience before specializing; age 28.

WOODWARD—*Continued*

ASSISTANT ADMINISTRATOR—35; B.S., M.H.A.; year's administrative residency; 3 years, comptroller, 350-bed hospital; 5 years, maintenance engineer large laboratory; will consider administrative assistant post large hospital; southeast only.

ASSISTANT ADMINISTRATOR—M.H.A.; several years, director, 40-bed general hospital; year's hospital residency; seeks very large hospital; middle 30's; prefers west.

ASSISTANT ADMINISTRATOR—7 years, Lieutenant Commander, USN; several years administrative residency; 4 years assistant administrator, 275-bed hospital; excellent achievements in hospital relations; seeks very large hospital, warm climate, NACHA.

ANESTHESIOLOGIST—2 years, instructor, anesthesiology, medical school and 6 years, successful clinical practice, anesthesiology; prefers chiefship, hospital or group; east or southeast; Diplomate.

COMPTROLLER—36; 3 years, accountant, 5 years, comptroller, hospitals 400, 175-beds respectively; seeks larger hospital with greater responsibilities; member, AAHA.

DIRECTOR OF NURSES—M.S. Nursing; 3 years, university teaching; 6 years, nursing experience; 2 years, assistant director, nursing service; seeks directorship, general hospital without school or with school where services, education are divided; 200-300 beds; midwest only; age 35; single.

PATHOLOGIST—4 years, teaching medicine; 7 years; senior pathologist 600-bed teaching hospital; specialist of highest order. Excellent background, hematology; Diplomate.

PATHOLOGIST—3 years, medical school faculty, pathology, and, also, 2 years, chief, laboratory services, its graduate hospital; any locality but prefers west coast, southwest; Diplomate, anatomy; age 31.

PURCHASING AGENT—B.S., M.S. (Business Administration); 5 years, manager, important hospital supply company; familiar, inventories, storeskeeping; prefers warm climate; $5000; middle 30's; immediately available.

RADIOLOGIST—4 years, associate radiologist, 500-bed general, fully approved, hospital; prefers Indiana, midwest; Diplomate.

RADIOLOGIST—Diplomate; well qualified, isotopes; past 2 years, associate chief and chief, 700-bed teaching hospital.

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ADMINISTRATOR—B.S. (cum laude); M.H.A.; six years, administrator 250-bed hospital; preceptor in Hospital Administration, two universities.

ADMINISTRATOR—Medical; has had two important administrative assignments since 1940; in both instances performance considered outstanding; highly regarded in field.

(Continued on page 196)

MEDICAL BUREAU—*Continued*

ADMINISTRATOR—R.N.; graduate, teaching hospital; six years' experience as anesthetist; recently completed administrative residency receiving M.H.A. from medical school program.

ASSISTANT—B.S. (Business Administration); M.H.A.; since completing residency, teaching hospital, has served as its personnel director, lecturer and coordinator, Program in Hospital Administration.

PATHOLOGIST—Diplomate; 4 years, associate pathologist, teaching hospital and on faculty of medical school as associate professor.

RADIOLOGIST—University hospital training in radiology; graduate training, isotopes; 6 years director department 250-bed hospital; Diplomate.

FOOD SUPERVISOR—B.S. (Major: Hotel and Restaurant Management); excellent experience.

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Cleveland, Ohio

ASSISTANT ADMINISTRATOR—Or Personnel manager; Age: 28. B.S. Degree, Business Administration; experienced counselor and personnel officer.

ADMINISTRATOR—Age: 35. M.H.A. Degree, mid-western university, 1954; 3 years administrator, 150-bed hospital; assistantship in larger hospital considered.

ADMINISTRATOR—B.S. Degree; New York University; Major Business Administration; (R.N.—charge nurse experience) past 10 years personnel supervisor; hospital superintendent; east or mid-west; available.

ADMINISTRATOR—M.A. Degree; 4 years director of pharmacy; purchasing agent; 3 years assistant director, teaching hospital; 7 years administrator, 200-bed hospital; any location.

EXECUTIVE HOUSEKEEPER—Age: 43 years; 10 years experience director, large unit—residence quarters; hotel housekeeper; 2 years director, housekeeping department, 400-bed western hospital.

ENGINEER—Extensive training; varied experience; past 3 years, 175-bed hospital; prefers northwest.

POSITIONS OPEN

ANESTHETIST—Registered nurse; second anesthetist needed for modern air-conditioned fully approved 70-bed hospital in Southern Illinois university town; excellent working conditions; salary open. Contact Jack Edmundson, Doctors' Hospital, Carbondale, Illinois.

ANESTHETIST—Registered nurse; for a 50-bed new, modern hospital; pleasant working conditions, good personnel policies; average number of surgical anesthetics per month, 46; adequate relief for week-ends and days off; salary open; two weeks paid vacation at end of year. Write Administrator Crawford County Memorial Hospital, Denison, Iowa. State age, training and experience.

classified advertising

POSITIONS OPEN

ANESTHETIST—Nurse; for obstetrics or surgery, salary open, three weeks vacation the first year, 12 days sick leave per year, accumulative. Apply to Personnel Director, Methodist Hospital, 1600 West 6th Avenue, Gary, Indiana.

ANESTHETIST—Nurse; to join obstetrical anesthesia staff; 40 hour week; salary adjusted to experience. Write Administrator, Highland Hospital, Rochester, New York.

ANESTHETIST—Nurse; new 223-bed hospital with modern equipment; active department. Apply Administrator, Bradford Hospital, Bradford, Pennsylvania.

ANESTHETISTS—Nurse: Excellent benefits including forty-hour week, four weeks vacation annually, assured annual salary increase, shift differential, non-contributory retirement plan and medical coverage; salary $5880.00 to $7080.00, depending on degree of qualifications; here is your chance to answer a challenge and to grow with it. For full details send your name and address to Miners Memorial Hospital Association, Box #61, 110 Logan Street, Williamson, West Virginia.

ASSISTANT DIRECTOR OF NURSING SERVICE—650-bed general hospital located in industrial city (300,000); primary responsibility to plan and supervise in-service program; experience and preparation in nursing service administration desirable. Write Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

ASSOCIATE DIRECTOR OF NURSING—650-bed general hospital located in industrial city (300,000 population); all new facilities, hospital opened in 1954; experience required; Masters degree in Nursing Service Administration preferred. Write Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

ASSOCIATE MEDICAL DIRECTOR—100-bed tuberculosis hospital, North American graduate; salary $8500-9500; complete maintenance. Apply Medical Director & Superintendent, District One Tuberculosis Hospital, Madisonville, Kentucky, or State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

DIETITIAN — Assistant Administrative: The dietitian who likes administration, a dietary department with annual turnover of 1%, modern equipment centralized mealpak service, and the excellent recreational facilities of Minnesota; immediate opening in 220-bed teaching voluntary general hospital. Write MO 179, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIAN—Modern kitchen, 74 employees, liberal food budget, 600-bed fully accredited hospital; no nursing school; social security and State retirement; salary range $3,588-$4,428; liberal annual and sick leave privileges; member A.D.A. preferred. Apply MO 169, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIAN—Immediate opening at 200-bed general hospital in the Detroit area, for qualified dietitian; 5 years working experience or ADA membership preferred; starting salary $5597.76 per year; excellent employment benefits. Contact Personnel Office, Pontiac General Hospital, Pontiac, Michigan.

DIETITIAN—A.D.A., B.S. degree and experience required; 5 day week, 4 weeks vacation, 2 weeks sick leave, 6½ holidays, social security, group insurance; 275-bed hospital in college town midway between Detroit and Chicago; salary open. Apply MO 181, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIAN—Assistants; food production or therapeutic; Teaching Hospital. Apply to Director, Department of Nutrition and Dietetics, University of Missouri, 807 Stadium Road, Columbia, Missouri.

DIETITIANS—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—A.D.A.; to head department; 100-bed general hospital; duties include cafeteria, general and therapeutic diet planning, patient contact, general supervising, teaching student nurses; maintenance available. Apply Hospital Administrator, St. Joseph's Hospital, Lewistown, Montana.

DIETITIAN—Registered; qualified to assume full department head duties if necessary; 156-bed general hospital located in central Ohio. Complete details upon request to Administrator, Marion General Hospital, Marion, Ohio.

DIETITIAN—Head; modern 223-bed hospital; no school of nursing. Apply Administrator, Bradford Hospital, Bradford, Pennsylvania.

DIETITIAN — Administrative, assistant to chief; for a 306-bed teaching hospital with diagnostic clinic; a large full-time medical staff and house staff, salary open, progressive personnel policies. Apply Chief Dietitian, Geisinger Memorial Hospital and Foss Clinic, Danville, Pennsylvania.

DIETITIAN—Therapeutic, assistant to chief; for a 306-bed teaching hospital with diagnostic clinic; a large full-time medical staff and house staff, salary open, progressive personnel policies. Apply Chief Dietitian, Geisinger Memorial Hospital and Foss Clinic, Danville, Pennsylvania.

DIETITIAN—Registered; chief dietitian to head department in 150-bed modern general hospital; attractive salary; twenty-five employees including an assistant. Apply Administrator, Yakima Valley Memorial Hospital, Yakima, Washington.

DIETITIAN — A.D.A.; therapeutic; 160-bed general hospital, college town, 20 miles west of Milwaukee; major expansion program to be started in spring of 1957; modern dietary department completely remodelled in 1954-55. Apply Personnel Department, Waukesha Memorial Hospital, Waukesha, Wisconsin.

DIETITIAN — Chief; college degree, A.D.A. member, experience in supervision and marketing; $400 per month start; liberal personnel policies; good working conditions. Write Personnel Office, The Queen's Hospital, Box 614, Honolulu, Hawaii.

DIRECTOR OF NURSES — 100-bed hospital now being enlarged to 180-beds; adequate training and experience required; salary open. Apply Administrator, Municipal Hospital, Virginia, Minnesota.

(Continued on page 198)

DIRECTOR OF NURSING SERVICE—200-bed general hospital in suburb of Washington, D.C. fully approved; no training school; new air-conditioned wing; salary open. Apply Suburban Hospital, Bethesda, Maryland.

DIRECTOR OF PERSONNEL—Male or female with degree or equivalent training to assume complete responsibility for the personnel department and public relations of expanding 200-bed hospital. Submit full qualifications and photograph in reply to Pontiac General Hospital, Pontiac, Michigan.

EDUCATIONAL DIRECTOR—Masters Degree and experience in teaching desirable; salary open, liberal personnel policies including 40 hour week, all cash salary, pension plan in addition to social security and hospitalization; living quarters available if desired; admit one class a year; three year diploma program; 300-bed hospital, 89 students; basic sciences taught at New Jersey Teacher's College; position open May 1957. Apply to Director of Nursing, The Mercer Hospital, Trenton, New Jersey.

HOUSEKEEPER — Executive; 175-bed voluntary general hospital, located on Gulf of Mexico; excellent working conditions, congenial staff; salary commensurate with qualifications. Reply Administrator, Morton Plant Hospital, Clearwater, Florida.

INSTRUCTOR—Obstetric nursing; in a fully accredited school of nursing; 170 students, 350-bed hospital in large metropolitan city with educational and cultural advantages; college affiliation; housing available; liberal personnel policies; salary open. Apply MO 180, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

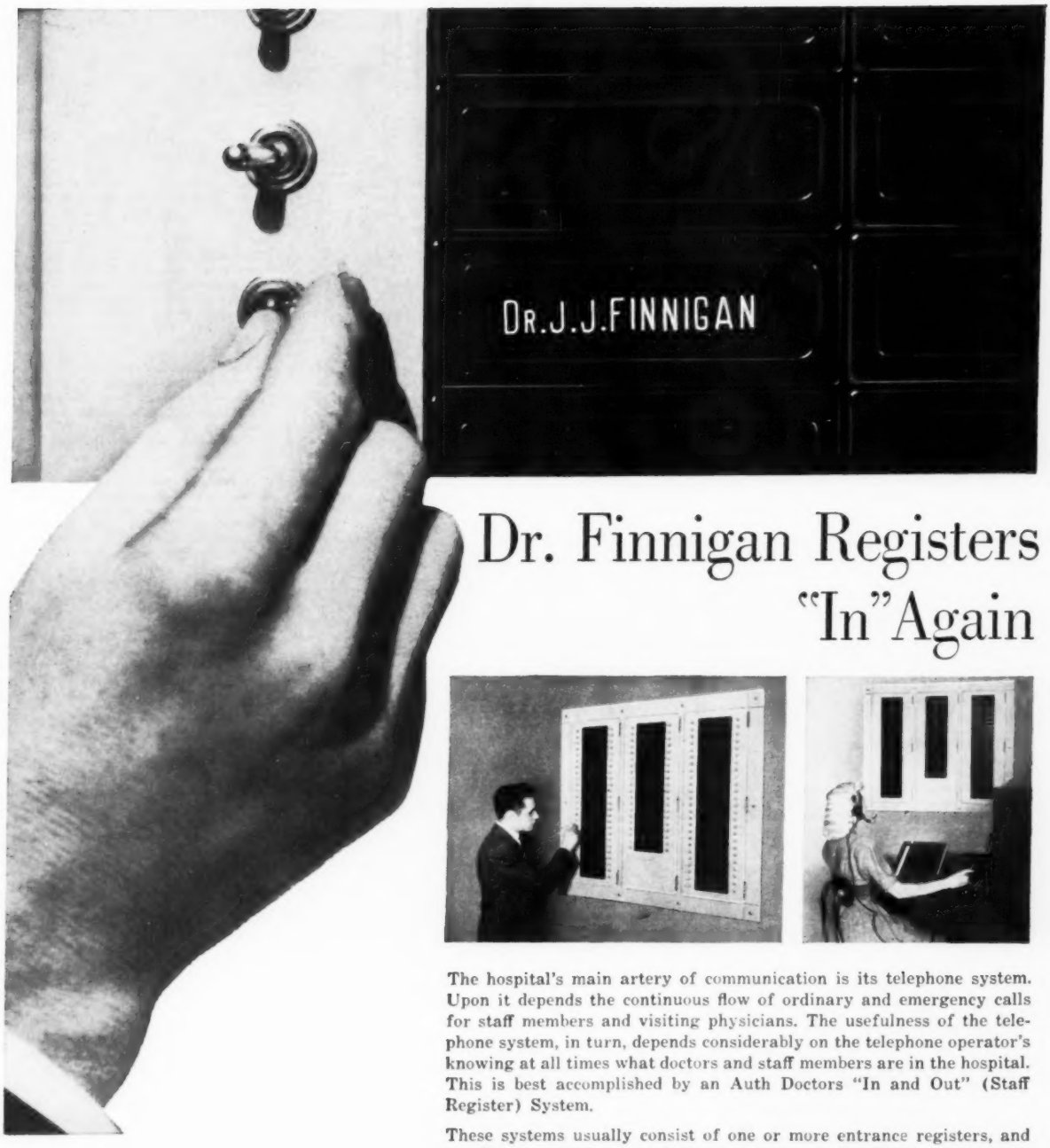
CLINICAL instructure in medical and surgical nursing; approved school of 50 students; all approved policies; B.A. required; M.A. desired. Write Director of Nursing, Danbury Hospital, Danbury, Connecticut.

INSTRUCTORS—Clinical; for obstetrics, medicine and surgery for expanding, modern hospital and school of nursing; Bachelor's degree required and experience in teaching and supervision desirable; attractive salary, sick leave, and four weeks vacation. Apply Personnel Director, Methodist Hospital, Gary, Indiana.

INSTRUCTOR—Psychiatric nursing; B.S. Degree required; $3300 yearly salary; furnished apartment, meals and laundry, 40 hour, 5 day week, paid vacation, 7 holidays and liberal sick leave; approximate starting date April 15. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

INSTRUCTOR—Psychiatric nursing; to assist director of psychiatric nursing education; degree and experience in teaching required; salary dependent upon qualifications and experience; good personnel policies; large psychiatric hospital, 3400-beds. Apply Director of Nurses, St. Louis State Hospital, 5400 Arsenal St., St. Louis, Missouri.

INSTRUCTOR—Clinical; in obstetrical nursing for both formal and clinical teaching; B.S. Degree and experience in teaching desirable; faculty being increased; liberal personnel policies; salary dependent upon qualifications and experience; admit one class a year, three year diploma program; 300-bed hospital, 89 students, position open for immediate appointment. Apply to Director of Nursing, The Mercer Hospital, Trenton 8, New Jersey.



Dr. Finnigan Registers "In" Again

The hospital's main artery of communication is its telephone system. Upon it depends the continuous flow of ordinary and emergency calls for staff members and visiting physicians. The usefulness of the telephone system, in turn, depends considerably on the telephone operator's knowing at all times what doctors and staff members are in the hospital. This is best accomplished by an Auth Doctors "In and Out" (Staff Register) System.

These systems usually consist of one or more entrance registers, and an office register for the telephone operator. As Dr. Finnigan registers in again he throws the switch alongside his name on the entrance register. This illuminates his name on all registers while he is in the hospital. When he leaves, he reverses the switch, darkening his name. An optional "Call-Back" feature alerts the doctor as he registers in or out, notifying him that the operator has a special message for him.

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INSTRUCTOR — Nursing Arts; B.S. Degree and experience in teaching desirable; salary dependent upon background and experience; liberal personnel policies; admit one class a year; three year diploma program; 300-bed hospital, 89 students; position open; have full time assistant instructor in this area. Apply to Director of Nursing, The Mercer Hospital, Trenton 8, New Jersey.

INSTRUCTOR FOR NURSES' AIDES—General hospital treating men, women and children; 128 adult and pediatric beds plus 24 bassinets; 40 hour week; salary open. Apply Director, Woman's Hospital, 1940 East 101st Street, Cleveland 6, Ohio.

INSTRUCTOR—Clinical pediatric nursing; Degree and experience in nursing of children required; school of nursing fully accredited; 650-bed non-profit hospital located in industrial city (population 300,000); 40 hour week; paid vacations; liberal benefits. Write Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

INSTRUCTOR—Clinical; obstetrics; school of 150 students; NLN, full accreditation; salary commensurate with experience and qualifications; hospital located near university where credits may be taken for one-half rate tuition; position open May 1, 1957. Apply Director of Nurses, Presbyterian Hospital, Philadelphia 4, Pennsylvania.

INSTRUCTORS—Nursing arts and science; for school of nursing in 110-bed general hospital; Degree in Nursing or Nursing Education preferred but work toward degree required; starting salary $300 to $350 with maintenance depending on training and experience. Apply Administrator, Camden Hospital, Camden, South Carolina.

INSTRUCTOR—Science; required by McKellar General Hospital, Fort William, Ontario; duties to commence early in August 1957; salary schedule $270-$300, additional recognition for experience; good personnel policies. Apply Director of Nursing.

LIBRARIAN—Registered record; for new 300-bed hospital; full charge in setting up new installation; located 30 minutes from New York City. Write stating education and experience. MO 170, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

LIBRARIAN—Medical records; to head large department in new 516-bed cancer research hospital; excellent opportunity; good salary and working conditions; qualifications: registration or graduate of approved school and at least one year experience. Write Box MO 177, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

LIBRARIAN—Medical record; for small hospital in North Jersey. Apply Bound Brook Hospital, 507 Church Street, Bound Brook, New Jersey.

LIBRARIAN—Superior opportunity for RRL to head medical records department in modern 650-bed general hospital; outstanding medical staff cooperation; excellent salary commensurate with experience; progressive personnel policies including social security and hospital pension plan. Contact Director, Miami Valley Hospital, Dayton 9, Ohio.

LIBRARIAN—Medical record; registered to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

LIBRARIAN—Registered medical records; To head department; also, opening for assistant to chief of department, in accredited hospital of 296-beds and 36 bassinets; 40 hour week and salary open. Apply to Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

MISCELLANEOUS—Nurses; Operating Room; Clinical Instructor and Staff Nurses; for teaching hospital within walking distance of Columbia University; salaries and personnel policies comparable to other hospitals in area. Write Director of Nursing, Box P, St. Luke's Hospital, New York 25, New York.

MISCELLANEOUS—Clinical Instructors; medical, surgical, obstetric and pediatric nursing. Supervisor, orthopedics and psychiatry; Staff Nurses; new modern hospital, progressive administration; excellent opportunity for qualified instructors; salary commensurate with qualifications. Apply to Nurse Administrator, Methodist Hospital, Lubbock, Texas.

MISCELLANEOUS—These positions have been created through the expansion of our Psychiatric Clinic; Psychologists; Social Workers, Occupational Therapists and Psychiatric Nurses; Applicants must be bilingual, highly qualified and recommended. Apply to Institut Albert Prevost, 6555 West, Boulevard Gouin, Montreal 9, P.Q.

NURSES—For rehabilitation and general duty; 100-bed treatment center near metropolitan areas offers nurses the opportunity for application of rehabilitation principles to carefully selected patients; 40-hour work week; salaries open pending application, liberal additional benefits. Apply Director of Nursing, Gaylord Farm Sanatorium, Wallingford, Connecticut.

NURSES—Veterans Administration Hospital, Montrose, New York; 1800-bed neuropsychiatric hospital located on the Hudson River, 40 miles from New York City; pleasant nurses residence; openings for men and women professional nurses, minimum annual salary $4025, 40 hour work week with 30 days vacation plus 8 holidays, 15 days sick leave. Write Chief, Nursing Service, Veterans Administration Hospital, Montrose, New York.

NURSES—General duty, operating room and delivery room; salary $315.00 to $351.00 per month plus department premium of $10.00; shift premium $20.00 extra per month; vacation up to 4 weeks; retirement program, and social security; hospitalization insurance, 40 hour week; hospital located on university campus. Apply Director of Nursing, Palo Alto Hospital, Palo Alto, California.

NURSES—General duty; interesting work and environment, salary and quarters excellent. Write Maynard MacDougall Memorial Hospital, Nome, Alaska.

NURSE—Head; new central supply unit; experience and organizational ability required; 5 day week, 2 weeks vacation, 2 weeks sick leave, social security, group insurance, 6½ holidays; 275-bed hospital in college town midway between Detroit and Chicago; salary commensurate with responsibility. Apply MO 182, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Operating room and staff; for 227-bed pediatric hospital in sunny California; salary $300 per month with differential for operating room and evening and night duty; 5 day, 40 hour week; liberal personnel policies including vacation, sick time and retirement. Apply Director of Nursing, Childrens Hospital Society, 4614 Sunset Blvd., Los Angeles 27, California.

(Continued on page 200)

NURSES—Male; all shifts; $330.00 evenings; $320.00 nights; $310.00 days; liberal benefits. Apply St. Anthony's Hospital, 2875 W. 19th, Chicago, Illinois.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

NURSES—Psychiatric; for all shifts in new 27-bed unit in general hospital of 275-beds; experience required; college town midway between Detroit and Chicago; salary commensurate with responsibility. Apply MO 183, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSE—Registered; interested in teaching practical nursing; opportunities to develop own program; school not approved at present; desire individual capable of developing program which will meet State approval; small town located in southeast Pennsylvania. Apply MO 144, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 day week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5105.

NURSES—Registered; for a 50-bed general hospital; 40 hour week, two weeks vacation, two weeks sick leave, six paid holidays paid Blue Cross-Blue Shield; room and board in pleasant nurses home; salary range $303 to $355 per month; increases every six months for two years; shift differential for evening and night work. Apply Illini Community Hospital, Pittsfield, Illinois.

NURSES — Registered; immediate openings; starting salary $240 month with opportunity for advancement; room, board and laundry annual vacation, liberal sick leave, 40 hour, 5 day week. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

NURSES—Registered; Massachusetts General Hospital, Boston, Massachusetts; excellent clinical facilities, opportunity for advancement and attendance at local colleges; liberal personnel policies. Apply Personnel Department A-10 for further details.

NURSES—Registered; 83-bed hospital comprised of 43-bed general hospital and 40-bed retired miners; starting pay $300 per month with periodical increases; nurses home reasonable charge for board and room; 40-hour week. $15 differential pay for evening shifts, liberal personnel policies; town of 9000 in the mountains. Apply Miners' Hospital, Raton, N.M.

NURSES — Registered; immediate openings; general duty, all shifts; salary open, plus meals and laundry of uniforms; liberal personnel benefits. Write, wire or call Administrator, Webster County Memorial Hospital, Webster Springs, West Virginia.

classified advertising

POSITIONS OPEN

NURSES—Registered; are you looking for something new? Staff and assistant head Nurse positions open in beautiful new University of Oregon Medical School Hospital located on hill overlooking Portland, Oregon; medical surgical, pediatric and psychiatric units; excellent opportunities for learning, both in clinical areas and on campus; staff members may take courses at reduced tuition rate ($3 per quarter hour) leading to baccalaureate or masters degrees at the nursing school on the campus; liberal personnel policies; the northwest is a wonderful place to live and work. Write to Director of Nursing Service for full information. U. of O. Medical School Hospital, 3181 S. W. Sam Jackson Park Road, Portland 1, Oregon.

NURSES—Registered: Excellent benefits including forty-hour week, four weeks vacation annually, assured annual salary increase, shift differential, non-contributory retirement plan and medical coverage; salary $4440.00 to $6420.-00, depending on degree of qualification; here is your chance to answer a challenge and to grow with it. For full details send your name and address to Miners Memorial Hospital Association, Box No. 61, 110 Logan Street, Williamson, West Virginia.

NURSES—Registered general duty; for 200-bed general hospital; salary $200 per month; 5½ day week; good personnel policies. Apply Director of Nursing, General Hospital, Sault Ste. Marie, Ontario.

NURSES—Registered staff; in 45-bed pediatric unit; all shifts; 5 day week; liberal policies; college town midway between Detroit and Chicago; salary commensurate with responsibility. Apply MO 184, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Registered staff medical and surgical; all shifts, 5 day week, 2 weeks vacation, 2 weeks sick leave, 6½ holidays, social security and group insurance; college town midway between Detroit and Chicago; salary commensurate with responsibility. Apply MO 185, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Staff; for new expanding hospital on Florida's west coast; salaries and personnel policies compare favorably with those in this area; 40-hour week, 4 weeks vacation, no shift rotation; Florida registration required. Apply Supervisor Nursing Service, Manatee Memorial Hospital, Brandenton, Florida.

NURSES—Supervisory and staff; 50-bed, well equipped modern hospital; basic salaries, general staff, $270; supervisory $300; 40 hour week, differential for nights, call, special training or experience; located in Hiway 99 halfway Seattle and Vancouver, B.C.; scenic, sports, fishing and hunting. Apply Administrator, Memorial Hospital, Sedro Woolley, Washington.

PHYSICAL THERAPIST — Man or woman; graduation from approved school required for new department located in 224-bed general hospital; excellent personnel policies. Apply Allen Memorial Hospital, Waterloo, Iowa.

SUPERINTENDENT OF NURSES—For 25-bed hospital in small town; nurse anesthetist would be preferable; salary according to qualifications. Apply Dr. R. E. Sitta, Chillicothe Hospital, Chillicothe, Texas.

TECHNICIAN—Laboratory; 150-bed general hospital; employ three full time and three part time technicians; salary open, full maintenance, attractive living conditions. Apply MO 174, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

SUPERVISOR—Operating room; for 553-bed hospital; newly built and equipped operating rooms; opened November 1956; active surgical schedule—approximately 40 procedures daily; student nurses rotated through O.R.; operating room technician program; attractive personnel policies; very pleasant working conditions; B.S. degree and experience required. Apply to the Director of Nurses, Western Pennsylvania Hospital, Pittsburgh 24, Pennsylvania.

TECHNICIAN — Laboratory; fully approved general hospital; 112-beds, attractive, friendly city of approximately 20,000 located easy transportation to and from Chicago; 40 hour week, sick leave, vacation, laundry, meals on duty and other attractive fringe benefits; salary open. Apply MO 178, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNOLOGIST—Medical; for 70-bed hospital; salary open. Apply Administrator, Cedar Valley Hospital, Charles City, Iowa.

TECHNOLOGISTS—Laboratory; 350-bed general hospital adjacent to University of Kentucky, in Lexington, "The Heart of the Bluegrass"; salary $250-$350, 40 hour week, vacation, sick leave, laundry, meals on duty, holidays, etc. Write Assistant Administrator, Good Samaritan Hospital, South Limestone Street, Lexington, Kentucky.

TECHNICIANS — Registered laboratory; 150-bed modern general hospital in Central Washington; starting salary $350.00-$400.00 depending on qualifications. For details write Pathologist, Yakima Valley Memorial Hospital, Yakima, Washington.

TECHNOLOGIST—Medical; Excellent benefits including forty-hour week, four weeks vacation annually, assured annual salary increase, shift differential, non-contributory retirement plan and medical coverage; salary $4020.00 to $5880.00, depending on degree of qualification; here is your chance to answer a challenge and to grow with it. For full details send your name and address to Miners Memorial Hospital Association, Box #61, 110 Logan Street, Williamson, West Virginia.

TECHNICIAN—Laboratory; A.S.C.P. or combined laboratory and X-ray technician; salary open, full maintenance, liberal personnel policy; immediate opening. Contact Administrator, Webster County Memorial Hospital, Webster Springs, West Virginia.

TECHNOLOGIST—Medical registered 160-bed general hospital, college town, 20 miles west of Milwaukee, major expansion program including new department of laboratory medicine to be started in spring of 1957; affiliation with Carroll College for training of medical technologists now in development stage; full time pathologist. Apply Personnel Department, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE CHICAGO

ADMINISTRATORS — (a) Assistant medical administrator, hospital group; would direct 400-bed unit on his own; midwest. (b) Medical consultant; prestige post; some travel. (c) To succeed director retiring after 22 years' tenure; 250-bed hospital, university city, west. (d) Director, voluntary general hospital, 150-beds, completed '51; plans nearing completion for 2½ million expansion program; east. (e) General hospital, 60-beds; currently under construction; Southern California; retired administrator interested working in small hospital eligible. (f) Assistant; Master's, minimum 2 years' experience required; 300-bed general hospital, approved JCAH; foreign operations, large company; $9800 (Fed. tax free), travel expenses. (g) Assistant director strong in business training and experience; minimum B.S. degree, M.H.A. desirable; 400-bed general hospital; college town, near New York City. (h) Clinic manager; 20-man group; university city, midwest. MH3-1

(Continued on page 202)

MEDICAL BUREAU—*Continued*

ANESTHETISTS—(a) Anesthetist-administrator; 40-bed plantation hospital; excellent opportunity to prove ability; top salary qualified person; Hawaii. (b) Staff; progressive hospital expanding to 130-beds; major seaport; most modern conveniences; $7200-$7500; Alaska. (c) Two staff, one OB, one surgical (no call); 400-bed hospital near New York Ctiy; to $6000. (d) Two; well-established group; Iowa college town; to $7200 plus annual bonus. MH3-9

DIETITIANS — (a) Chief; excellent opportunity outside United States; 400-bed renowned hospital, $6000. (b) Chief; new, modern, progressive 100-bed hospital; mountain resort area; $5000 up. MH3-2

DIRECTORS OF NURSING — (a) Director School, Service; 240-bed general hospital; consider assistant capable assuming more responsibility; University city, east; $7000-$10,000. (b) Director Nursing Service; administrative ability most important; 200-bed general hospital; Michigan resort center; $6500. (c) Director of Nursing; collegiate school; 240-bed hospital; well-organized program; minimum $6000; mountain state. (d) Male director of Nursing; 300-bed new hospital; teaching experience required; excellent California location. MH3-3

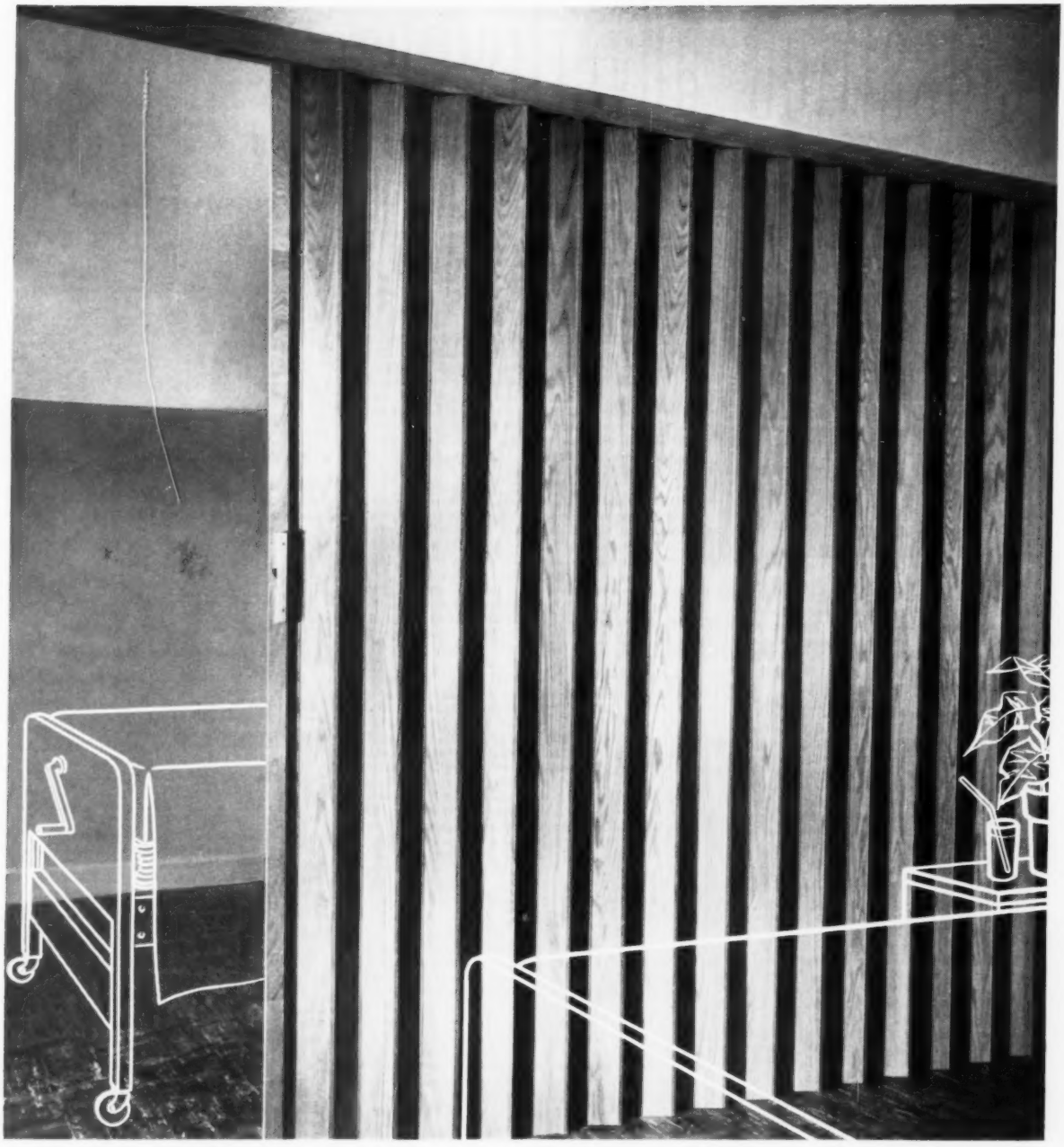
EXECUTIVE HOUSEKEEPER—Key city university hospital, 400-beds; department of 70; prestige position, east. MH3-4

EXECUTIVE PERSONNEL—(a) Chief accountant; 300-bed hospital; university city, midwest; $8000-$8500. (b) Accountant-consultant; important organization; some travel. (c) Director of personnel and public relations; 250-bed general hospital increasing to 450; lake resort town 75,000 near university center, midwest. (d) Engineer with hospital experience; state health department; $7000-$8000; midwest. (e) Food service director; newly created post; 250-bed hospital; attractive proposition. (f) Plant superintendent, city department, health and hospitals; complete authority; $7500; southwest. (g) Purchasing director; 350-bed general hospital; college town, midwest. (h) Chief of business division, city department of health and hospitals; Master's degree, 5 years' experience required; California. MH3-5

FACULTY POSTS—(a) Head, department of nursing, new two-year collegiate program; $6000, south. (b) Fundamentals of nursing; communicable disease; 300-bed hospital; foreign operations large industrial company; $9000; paid air travel. (c) Medical Surgical clinic instructor; 150-bed maternity hospital; leading midwest city; $5500. (d) OB clinical instructor; administration; teaching; renowned southern California Hospital; $4800. MH3-6

MEDICAL RECORD LIBRARIANS — (a) Chief; ability direct department of 900-bed university hospital; also supervise medical statistics service; $6500. (b) Chief; assume entire responsibility well-organized department; 200-bed renowned institution near Washington, D.C.; $5000 up. MH3-7

SUPERVISORS — (a) OB; 300-bed hospital near Lake Michigan; outstanding opportunity; start $5000. (b) OR; ability act as director 50-bed hospital, well organized cooperative nursing staff; Montana; $4000-$5000. (c) Central supply, OB; brand new 300-bed hospital



Privacy...when they want it

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This attractive wood "folding wall" gives patients the privacy they want—and need. Sound-retardant, quiet closing, too—these PELLA DOORS are also ideal for post operation and post delivery recovery rooms. Sanitary, too. No inside mechanism and folds of material to harbor dust and other foreign material. Still other uses include: nursing and intern class rooms, inside recreation areas, hospital meeting halls. Doors are available in natural wood veneers, or if desired doors can be painted to match your color scheme.

WOOD FOLDING DOORS

ROLSCREEN COMPANY
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Please send FREE 6-page folder on PELLA WOOD FOLDING DOORS.

NAME _____ TITLE _____

HOSPITAL _____

ADDRESS _____

CITY _____ ZONE _____ STATE _____

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

near New York City. (d) Psychiatric, male or female; to become manager 50-bed private sanitarium; salary, percentage; midwest. (e) Supervisor, Latin America; assist nursing service director; 160-bed American owned industrial hospital; must speak Spanish; $7200. MH3-8

ADMINISTRATORS — (a) Medical; Hebrew; 350-bed voluntary hospital; about $18,000; south-central. (b) 325-bed voluntary general hospital fully approved; midwest. (c) General JCAH hospital; building program under way, will increase size to 200-beds; south. (d) 200-bed hospital; superior facility; prefer degreed man, ACHA affiliation; large city, university medical center; midwest. (e) 200-bed general hospital; Washington D.C. area. (f) 150-bed JCAH hospital; outstanding Board; prefer southerner with degree; college town, 30,000; south. (g) General hospital expanding to 80-beds; should be experienced with building programs; $7,200; midwest. (h) General hospital, 60-beds; construction starting soon; post available immediately; southeast. (i) 40-bed hospital opening very soon; north central. (j) Small specialized hospital; established 1928; Bay area; California. (k) 120-bed hospital; New York State.

ADMINISTRATORS — Women; (aa) 175-bed voluntary, general hospital; requires degree or experience; east. (a) R.N. or non-medical; 60-bed general hospital to be completed soon; Florida resort community. (b) R.N. or non-medical, degree or excellent experience; voluntary general hospital 125-beds; $8000; small town near important eastern university city. (c) R.N.; 60-bed general hospital, expansion just completed from 30-beds; to $6500; residential area; midwest. (d) R.N. or non-medical, experienced proprietary hosptial operation; 30-bed general hospital, outpatient clinic; to $8000; western mining community.

ASSISTANT ADMINISTRATORS—(a) 150-bed hospital, doubling capacity; requires degree and experience; $10,000-$12,000; mideast. (b) Service director; requires M.H.A., very large hospital; teaching program; $7,200-$9,000; east. (c) 275-bed JCAH hospital; desirable university city, adjacent all outdoor sports area; equable year round climate; should be qualified in purchases, public relations; Pacific Northwest. (d) With business degree & several years hospital experience including systems, purchases & preferably hospital construction background; 400-bed hospital; $7,500-$8,000, minimum; more if experience warrants; seaboard, east. (e) 200-bed fully approved hospital; $5,700-$6,700; civil service; New England.

ADMINISTRATIVE POSTS—(a) Accountant; large general hospital; $5,000; Connecticut. (b) Accountant fairly large general hospital, vicinity Milwaukee. (c) Accountant; new post as hospital auditor; report to comptroller; $5,000, large hospital; Michigan. (d) Business manager; 500-bed hospital; $6,000; California. (e) Business manager; new smaller hospital; Florida. (f) Business manager; supervise five; hospital-clinic, 8 men; 50-beds; California; $6,000. (g) Clinic manager; 12 doctor group; research program; 225-bed teaching hospital; midwest. (h) Business manager; clinic staffed by 5 Diplomates; New Mexico. (i) Clinic manager; 13 Diplomates; $9,000 Indiana. (j) Business manager large TB hospital; $6-7,000; Michigan.

ANESTHETISTS—(a) Well established 12-man clinic group, affiliated 65-bed hospital; $6000; midwestern college community 10,000. (b) General hospital 35-beds; to $6000; small residential town, agricultural area; south. (c) Fully approved, very large general hospital; large industrial city near New York City. (d) New 50-bed general hospital, part time anesthesiologist heads department; to $7200; progressive town 7500, Pacific Northwest.

DIETITIANS—(a) Full responsibility for building department, new 150-bed general hospital opened late 1955, potential 250-beds; exclusive California residential city. (b) Chief; prefer some knowledge therapeutics; approved 100-bed general hospital; state capital, east. (c) Full charge department, 100-bed general facility; about $4800, partial maintenance; southern town 15,000. (d) Small general hospital, new 50-bed facility to be built; town 15,000; west-central.

DIRECTOR OF NURSES — (a) University affiliated general hosptial 250-beds; approved training school; to $8000; progressive eastern city. (b) Nursing service and education; 50 students; accredited 200-bed general hospital, expanding soon; to $7500, full maintenance; lake resort city 50,000, near university medical center; mideast. (c) Nursing service only; 200-bed voluntary general hospital approved JCAH; state capital, college city 75,000; southeast. (d) Nursing service and education; expanding school emphasizing full accreditation; voluntary general hospital 150-beds; to $7200; lovely midwestern city 25,000. (e) Nursing service; university hospitals; extensive expansion program to provide total 450-beds by 1959; $6000; Pacific Coast.

EDUCATIONAL DIRECTORS—(a) Associate, plan and execute curriculum; nearly 100 students in approved school; 300-bed voluntary general hospital; $4200; eastern resort city. (b) Accredited 3-year diploma-degree program, 300-bed general hospital; large capital city, southwest. (c) Voluntary general hospital 250-beds; lovely Southern city. (d) Direct hospital, collegiate affiliation in pediatrics for 100-bed children's hospital; $6000; midwestern college city 125,000.

EXECUTIVE HOUSEKEEPERS—(a) Supervise staff of over 50, fully approved voluntary general hospital 350-beds; midwestern university city, many cultural advantages. (b) New 325-bed, fully air-conditioned facility to open soon, replaces 100-bed hospital; southern college city 100,000. (c) Staff of 50 in department, voluntary general hospital 500-beds; lovely city, ideal Pacific Northwest location.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—(a) 250-bed mid-western hospital. (b) 375-bed specialized hospital, mid-western industrial city; M.H.A. Degree; 3 years experience. (d) 40-bed hospital, north central state. (e) Assistant; 175-bed Ohio hospital. (f) 50-bed West Virginia hospital.

(Continued on page 204)

WOODWARD—*Continued*

INTERSTATE—*Continued*

BUSINESS MANAGER—(a) 210-bed hospital, chronic diseases, mid-west. (b) 200-bed hospital, Pennsylvania. (c) Controller; 150-bed Ohio hospital. (d) 175-bed New Jersey hospital. (e) Auditor; 500 bed mid-western hospital.

PERSONNEL DIRECTOR—(a) 235-bed Ohio hospital. (b) 285-bed hospital, New York State. (c) Mental and nervous hospital, mid-west; $5500. (d) Large Sisters' hospital, new; south.

DIRECTOR, SCHOOL OF NURSING — (a) 500-bed eastern hospital. (b) 250-bed mid-west. (c) Instructors — clinical specialties; nursing arts; science; open June-September.

DIRECTOR, NURSING SERVICE—To $7,000.

EXECUTIVE HOUSEKEEPER—(a) 250-bed New Jersey hospital. (b) 300-bed hospital, mid-west. (c) Sisters' hospital, new; south.

DIETITIANS—Chief, $6,000; attractive situations.

SHAY MEDICAL AGENCY

Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

EXECUTIVE PERSONNEL — (a) Personnel director; midwest; 400-bed hospital; 3-5 years experience in hospital personnel; some public relations; $7000. (b) Controller; 200-bed hospital; midwest; good accounting experience. (c) Personnel relations officer; southwest; 350-bed hospital; about 650 employes. (d) Administrative assistant; woman; nursing experience preferred; 500-bed hospital; $7200. (e) Personnel director; east; 140-bed hospital; new position in administrative set-up; excellent opportunity. (f) Assistant administrative services director; east; large hospital; college degree with major in business administration preferred; to $8000.

PHYSICAL THERAPISTS—(a) Chief; middle west; 200-bed hospital; new therapy department just completed; $6000. (b) Staff; California; 400-bed hospital; excellent personnel policies; $5400. (c) Chief; south; 250-bed hospital in city of 75,000. (d) Staff; east; 350-bed hospital; active therapy department; $4800.

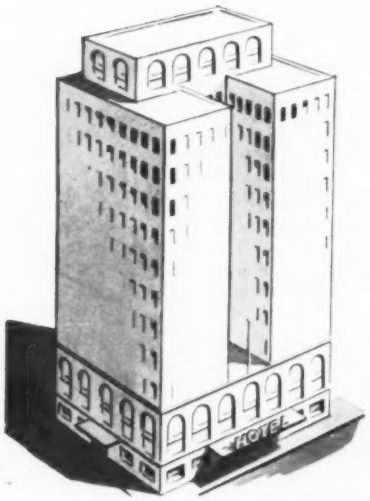
SOCIAL WORKERS—(a) Consultant; prepare policies and standards for a public health medical social work program; $6000. (b) East; psychiatric; require 4 to 5 years experience; complete charge of social service; $6000. (c) Middle west; direct activities of mental health center in city of 150,000; excellent staff; $5400 minimum. (d) East; director of social service department of 500-bed hospital; $6000.

MEDICAL EMPLOYMENT SERVICE

59 East Madison Chicago 2, Ill.
ANdover 3-5663-64
Alfred E. Riley, R.N., MSHA Director
Dorothea Bowlby, Counselor

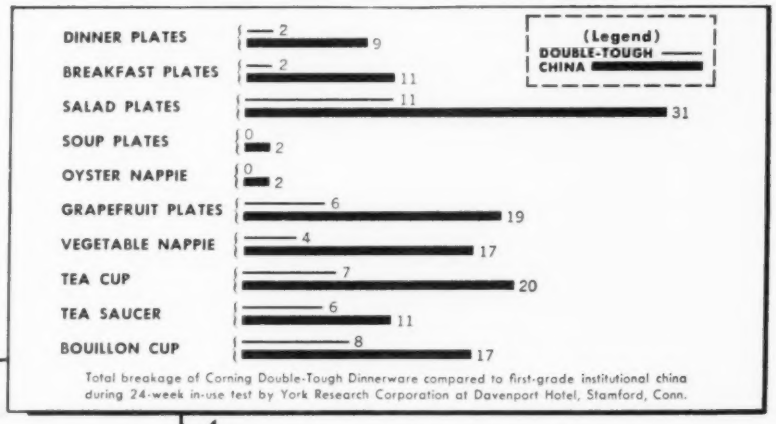
ADMINISTRATORS — (a) 300-bed hospital; Michigan; (b) 300-bed hospital; Ohio. (c) 325-bed University Hospital; midwest; MHA degree required plus 10 years experience; excellent opportunity; salary open. (d) Hospital consultant; west; $7,200 plus expenses. (e) 150-bed new hospital; west; MHA degree plus three years experience required. (f) 125-bed hospital; west; salary open. (g) 100-bed general hospital; south; new building; salary open. (h) 220-bed hospital; east coast area; salary open.

Independent test proves Double-Tough Dinnerware lasts 3 times as long as first-grade china!



York Research Corporation conducts this survey at official test hotel for American Hotel Association

LOOK what the York test proves!



Total breakage of Corning Double-Tough Dinnerware compared to first-grade institutional china during 24-week in-use test by York Research Corporation at Davenport Hotel, Stamford, Conn.

Hotel Davenport

October 15, 1956

York Research Corp.
Research Drive,
Stamford, Conn.

Gentleman:

The test using the Corning Double-Tough Dinnerware at the Hotel Davenport revealed several interesting things which may not have shown up in regular laboratory testing.

First of all, the washing cycle of the Corning Double-Tough ware was less than the washing cycle for regular china. Also, the Corning Double-Tough ware was much easier to keep clean and maintain than regular china. Secondly, the coffee saucers stacked much better than regular saucers, even though the design of the Corning Double-Tough does not differ greatly from the china which we ordinarily use.

I can certainly recommend the Corning Double-Tough for every institutional use as it meets every requirement for such use. Certainly this item should meet with good response from any institution requiring a good dinnerware with a minimum of replacement.

Cordially,

HOTEL DAVENPORT

Robert N. Wish
Manager

LOOK what the hotel manager says!

● Choose from six smart patterns of Double-Tough Dinnerware—traditional green or maroon bands or solid borders of Coral, Gray, Autumn or Aqua. Also choose from four different designs of Double-Tough Tumblers. Order from your dealer now!

Send for this FREE booklet that will help you cut costs!

● We'll be glad to send you this free booklet that gives all the facts about Corning Double-Tough Dinnerware and shows how it can cut your costs. Just mail the coupon and we'll send you the free booklet without any obligation on your part.

Corning Glass Works
Corning, N. Y.

Please send me, without obligation, your free booklet which tells how Corning Double-Tough Dinnerware can cut my tableware replacement costs and improve my service.

NAME_____

BUSINESS OR INSTITUTION_____

STREET_____

CITY_____ STATE_____

CORNING DOUBLE-TOUGH Dinnerware

Made by the maker of famous PYREX brand ware Consumer Products Division, Corning Glass Works, Corning, N. Y.

classified advertising

POSITIONS OPEN

MEDICAL EMPLOYMENT—

ASSISTANT ADMINISTRATORS—(a) 200-bed hospital; south. (b) 500-bed; south; MHA degree required; salary open. (c) 350-bed on east coast; excellent opportunity. (d) 225-bed hospital; west; will take over hospital in one year; excellent salary, living conditions, beautiful city. (e) 300-bed hospital; Texas; MHA degree, plus experience with machinery and equipment required; salary $8,500 per annum. (f) 50-bed hospital; south; Superintendent; salary $6,000. (g) 150-bed hospital; east coast; salary open. (h) 300-bed hospital expanding to 500-beds; 1st Assistant Administrator needed; must have degree and 5 years experience; excellent opportunity; large city.

DIETITIANS—(a) Chief; 400-bed hospital; midwest medical center; all new facilities, 70 employees, salary $7,200. (b) Director of food service; Michigan; $6,000.

PHARMACISTS—(a) 250-bed hospital; Ohio; $6,000. (b) 300-bed hospital; California; $6,000. (c) 300-bed hospital; south; open.

TECHNOLOGISTS — (a) ASCP technician; $400 per month; college town; upper midwest. (b) 150-bed hospital; large midwest city; salary open, full maintenance, attractive living conditions. (c) Bacteriologists all levels midwest; salary open. (d) Chemists; midwest; salary open.

PLACEMENT BUREAUS

PROFESSIONAL MEDICAL BUREAU
Division of
Professional Nurses Bureau

6087 Sunset Blvd. Los Angeles 28, Calif.
John Patterson, Director

Marcella O'Sullivan, Assistant Director

We are pleased to provide confidential service to applicants and employers in the hospital, medical and allied fields. We welcome all inquiries regarding available positions or our well qualified candidates.

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Nation-wide placement service for Physicians, Administrators, Anesthetists, Dietitians, Nurses, Technicians, Pharmacists, Comptrollers, Accountants, Secretary, Housekeepers, etc.

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Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven methods shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

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Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

(Continued on page 206)

FOR SALE

NURSING AND MEDICAL BOOKS

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

Delivery Room Equipment; Delivery Tables; Baby Incubator; large number of Individual Bassinettes of various types in very fine condition. Obstetrical Forceps; Electric Breast Pump. Also Major Hydraulic Operating Tables, etc.

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MISCELLANEOUS

HOSPITAL PERSONNEL
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Excellent benefits including forty-hour week, four weeks vacation annually, assured annual salary increase, shift differential, non-contributory retirement plan and medical coverage.

Salaries vary due to degree of qualifications. Nurse Anesthetists $5880.00 to $7080.00; Registered Nurses $4440.00 to $6420.00; Medical Technologist $4020.00 to $5880.00.

Here is your chance to answer a challenge and to grow with it.

For full details just send your name and address to Miners Memorial Hospital Association, Box No. 61, 110 Logan Street Williamson, West Virginia.

HOSPITAL ADMINISTRATION

A vacancy exists for an Assistant Hospital Administrative Services Director in one of Philadelphia's large general hospitals. This position offers an excellent opportunity to gain well rounded experience in a very progressively run institution. Requires; bachelors degree in Business or Public Administration and masters degree in Hospital Administration plus 2 years experience in Hospital Administration including 1 year in an administrative capacity in a large institution. Start $7265 per year. Please send resume: Personnel Department, Room 975.c City Hall, Philadelphia 7, Pennsylvania.

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Well rounded pharmaceutical line consisting of injections, capsules, tablets and other important products frequently used by hospitals.

Well accepted and recognized line now used by hundreds of leading institutions. Replies confidential. Apply HS 16, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

WANTED, complete library of back copies of The MODERN HOSPITAL. Tell issues available, price, etc. Write Box MS 15, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

(Continued on page 208)

SCHOOLS—SPECIAL INSTRUCTION

GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Registration fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing Service, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

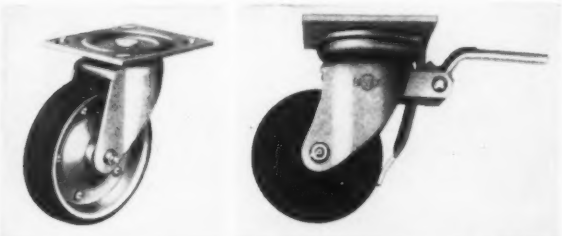
SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

Oxygen tent rolls safely on conductive Bassick casters

Here's another fine piece of hospital equipment that gets mobility from Bassick casters.

The Ohio Chemical and Surgical Equipment Company, Madison, Wisconsin puts this Model 25 Oxygen Tent on Bassick casters with conductive wheels that dissipate static charges.

These 4" Bassick casters roll smoothly and swivel easily, too. There's no sticking of wheel or swivel that might cause a sudden lurch or accident. And Bassick casters are noted for long wear, low maintenance. THE BASSICK COMPANY, Bridgeport 2, Conn. *In Canada:* Belleville, Ontario. 7.5



There are sizes and types of Bassick Truck Casters for all kinds of handling equipment—food carts, service trucks, laundry baskets, portable racks, etc. Casters with wheel and swivel locks, special stems for angle iron and tubing. Look to Bassick for casters.

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"We are completely satisfied in every way"

This statement is typical of hundreds we hear year after year... high tribute to Akron's proven dependability.

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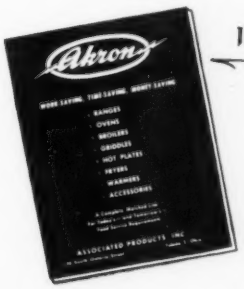
EQUIPPED KITCHEN MAKING MANY LOYAL FRIENDS

Akron's best boosters are users of the equipment. They have learned they can always depend on Akron's consistent and unvarying high performance.

It will pay you to look into all the facts that are creating the fast growing preference for Akron.

The Akron line of electric cooking is complete . . . matched units help to design kitchen layouts for the greatest possible efficiency to save work, time and money.



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SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in OBSTETRIC NURSING to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

SCHOOLS—SPECIAL INSTRUCTION

The BOSTON LYING-IN HOSPITAL offers to qualified registered nurses a six-months internship in maternity nursing. Clinical experience is offered in all phases. This includes antepartal clinics, delivery room, postpartum and diabetic unit, normal newborn, and premature nursery. Each nurse intern will have the opportunity to deliver a mother under supervision. An elective period will be spent in advanced experience in the area of choice. Room, laundry, food allowance and a stipend of $75 per month is granted. Rooms are provided in a graduate house. The registration fee is $20. For complete information write to Carolyn Davies R.N., Director of Nurses, Boston Lying-in Hospital, Boston, Massachusetts.

SCHOOLS—SPECIAL INSTRUCTION

UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all techniques in inhalation, intravenous, and rectal anesthesia. Unlimited opportunities for endotrachael intubation and open chest anesthesia. Stipend provided. For information write, School for Nurse Anesthetists, University Hospital, Ann Arbor, Michigan.

TOO LATE TO CLASSIFY

POSITIONS WANTED

ASSISTANT ADMINISTRATOR—Female; age 27; B.S. Pharmacy; M.P.H. Yale University Hospital; experience. Apply MW 137, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

HOUSEKEEPER—Executive; male; diversified experience organizational and managerial abilities; even for short contract available. Apply MW 138, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

POSITIONS OPEN

LIBRARIAN—Medical record; registered record librarian required to take charge of department in 250-bed hospital, in operation one year; excellent personnel policies including liberal vacation; salary open. Apply to H. V. Snyder, Administrator, Sudbury Memorial Hospital, Sudbury, Ontario.

FOR SALE

CORMAC PHOTOCOPY MACHINE, one and one-half years old; excellent condition; original price $359.00, will sacrifice for $175.00. Write M. C. Turley, Business Manager, Memorial Hospital, P.O. Box 4246, Owens Station, Charleston 4, West Virginia.

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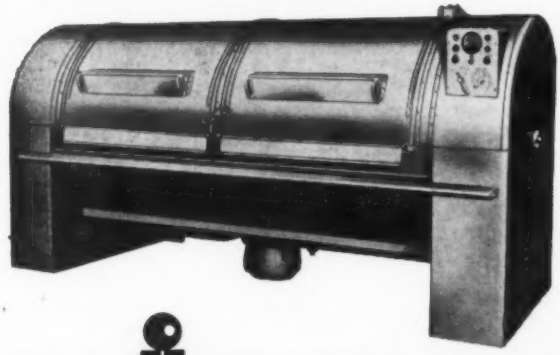
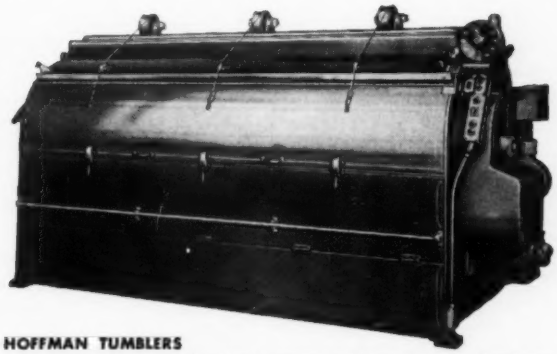
COMPLETE LAUNDRY EQUIPMENT SERVICE
by
HOFFMAN

Hoffman provides an all-inclusive service to simplify every step in the planning, equipping and operation of your new or modernized laundry. Whatever the size or special requirement of your laundry needs, consult your Hoffman Laundry Engineer for his authoritative recommendations assuring lowest operating costs, maximum production, greatest savings.

HOFFMAN WASHERS
Save extra time and work with a Hoffman Unloading Washer (above) which transfers work directly, automatically, into trucks or basket halves from an unloading extractor. Standard model (below) has open-pocket or horizontal partition and reinforced, all-welded stainless steel construction throughout. Hoffman also offers a range of washers with side-loading or open-end loading for small lots and re-runs.



HOFFMAN LAUNDRY EXTRACTORS
Model shown is an Unloading Laundry Extractor which avoids manual handling of work, speeds production and saves manhours. Also, Hoffman Open-top Laundry Extractors in 40 and 48-inch basket diameters. Smaller Hoffman Extractors are the 17, 26, and 30-inch Steel Curb models. All three types assure you high-speed acceleration, powerful braking for quick stops and maximum extraction . . . truly unparalleled efficiency in their size and type ranges.

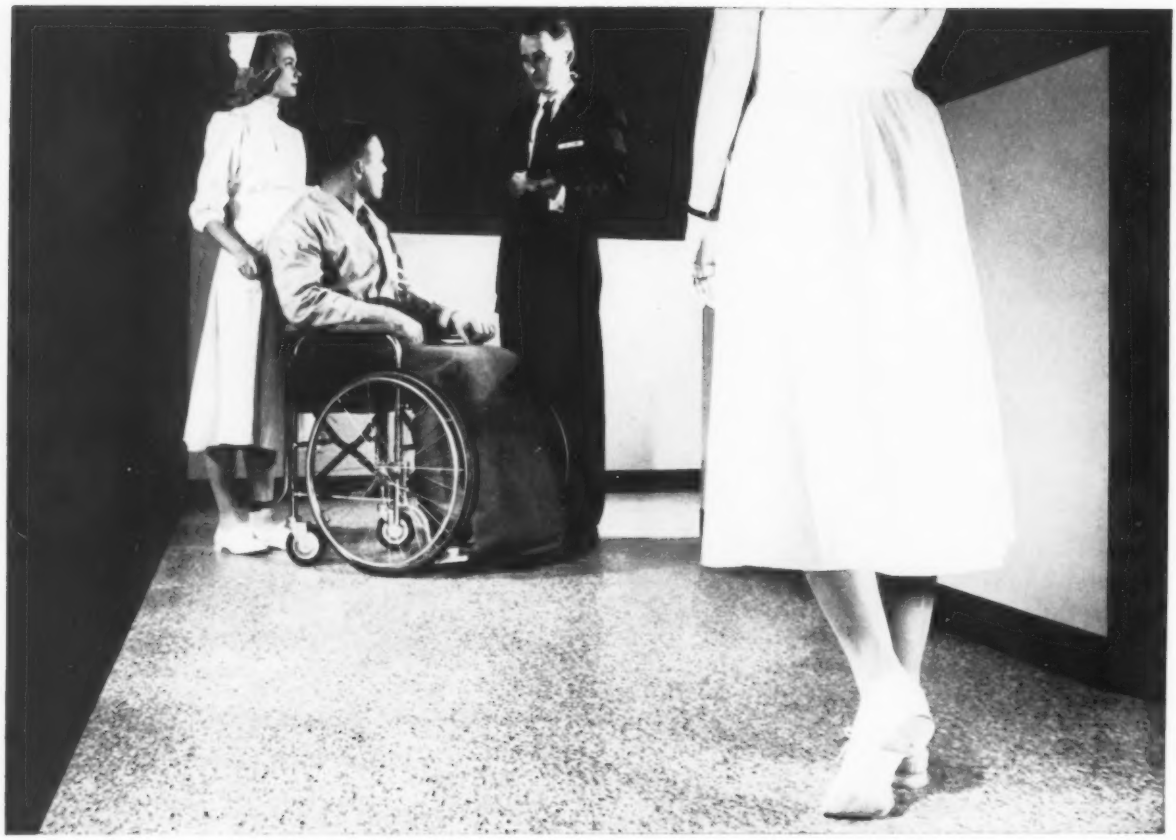


HOFFMAN TUMBLERS
The "Balanced-Suction" Tumbler is available in two types: re-circulating or once-through, both of which have separate motors for cylinder and fan. For quick and easy loading and unloading Hoffman also makes an Open-end Tumbler with high-velocity fan and improved down-draft method of directing air through load combine to give fastest low-temperature drying.

H O F F M A N
A COMPLETE LINE OF EQUIPMENT • A COMPLETE LAUNDRY SERVICE

For additional information and literature, please call your nearby Hoffman representative, or write:

U.S.HOFFMAN MACHINERY CORPORATION 105 FOURTH AVENUE, NEW YORK 3, N.Y.



JUST THE PLACE FOR NEW GOLD SEAL SEQUIN* 1/8" INLAID LINOLEUM!

This new, exclusive flooring resists wear— keeps its pattern as no other 1/8" linoleum can!

Abrasive Wheel Test proves *Sequin* will "look like new" through long service life!

The circular "After Test" area is the result of applying the abrasive wheel to the "Sequin" sample. See how it has worn well through the linoleum—and yet the pattern is still there, as clear and sharp as ever! Compare it with the "Before Test" area. You can't tell the difference! For information and samples write to Customer Service Dept., Congoleum-Nairn Inc., Kearny, N. J.

Here is an ideal floor covering for hospital corridors and rooms—and other heavy traffic areas! Gold Seal "Sequin" wears and wears. It gives a sanitary, virtually seamless expanse of wall-to-wall floor. The satin-smooth surface seals out dirt and resists stains...it's so easy to keep clean and sparkling!

Gold Seal "Sequin" is highly resilient . . . quiet and comfortable underfoot. Seven patterns provide a wide selection to match any decorative plan. See the distinctive, new "Sequin," get full information at your Gold Seal Dealer's today!

SPECIFICATIONS:
6-ft. wide yard goods, 1/8" gauge burlap backed. Install over suspended wood or suspended concrete subfloors. Available in: grey, green, dark brown, white multi, grey mix, taupe, beige. Also made in standard gauge for residential use—in 18 colors.

FOR HOME OR BUSINESS:

INLAID BY THE YARD—Linoleum • Nairon* Standard • Nairontop*
RESILIENT TILES—Rubber • Cork • Nairon Custom • Nairon Standard Vinylbest • Linoleum • Ranchtile® Linoleum • Asphalt
PRINTED FLOOR AND WALL COVERINGS—Congoleum® and Congowall®
RUGS AND BROADLOOM—LoomWeve*

FOR THE LOOK THAT'S YEARS AHEAD
Gold Seal® FLOORS AND WALLS
*Trademark

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 248. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Alcohol Dispenser Is Pedal-Activated

The new Tomac Alcohol Dispenser delivers a stream of alcohol by merely

depressing the foot pedal. A large size plastic drain bowl catches the overflow which empties into the lower of the two plastic bottles. The two quart polyethylene bottles are interchangeable. The three point suspension base provides perfect balance and rubber feet protect the floor. **American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Ill.**

For more details circle #428 on mailing card.

Non-Adhering Dressing in Sterile Package

Individually packaged in a sterile envelope, Adaptic Non-Adhering Dressing is a fabric of woven viscose filaments. The weave is tight enough to prevent growth buds of new skin from growing through the dressing. It is impregnated with an especially formulated bland oil in water emulsion which allows the pores of the fabric to remain open. This results in maximal drainage while avoiding adherence to the wound.

Adaptic is a primary surgical dressing effective on any type of surgical lesion. The versatile dressing has a sidewise stretch for conformability to all contours without wrinkling. It is effective for use on burns, skin grafts, plastic surgery, colostomies, open ulcers, ileostomies and cases where packing is needed. **Johnson & Johnson, New Brunswick, N. J.**

For more details circle #429 on mailing card.

Two Serving Platters in Double-Tough Dinnerware

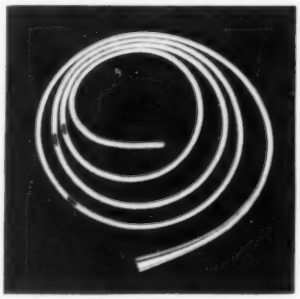
Two new serving platters have been added to the line of Corning Double-Tough Dinnerware. The platters measure 9½ and 11½ inches in outside diameter and are available in green and maroon band trim or with gray, coral, autumn and aqua sprayed borders. This brings the line of Corning tempered, heat-resistant dinnerware to 24 pieces. **Corning Glass Works, Corning, N. Y.**

For more details circle #430 on mailing card.

Plastic Catheters Are Disposable

A new line of Davol Plastic Catheters and Surgical Tubes has been designed for one time use. The low-cost units are conveniently packaged in heat-sealed, transparent plastic envelopes for quick identification.

Major improvements include full flared funnels of one piece construction, well rounded eyes, softly beveled tips to prevent trauma and satin-smooth inside



surfaces and finish. Items in the line include Green oxygen catheters, suction catheters and DeLee tracheal catheters; rectal, infant feeding, Green oxygen connection and improved Levin duodenal tubes. **Davol Rubber Company, Providence 2, R.I.**

For more details circle #431 on mailing card.

Saran Wrap in Large Dispenser

The Ready Roll has been designed to dispense Saran Wrap for easy handling in institutional applications. The handy corrugated cardboard dispenser box holds a 1000 foot roll of Saran Wrap in both 12 and 18 inch widths. Saran Wrap is ideal for wrapping foods to be frozen, for covering foods prepared in advance and for covering trays enroute to patient rooms. **The Dow Chemical Co., Plastics Sales Dept., Midland, Mich.**

For more details circle #432 on mailing card.

(Continued on page 214)

Edison Deodorant Works By Fixation

Odors are eliminated by fixation when attacked by the new Edison Hospital Type Deodorant. The product is non-flammable, non-toxic, non-allergenic, non-staining and odorless in use. It is supplied in a concentrate for dilution in use. The product has no masking perfumes or nerve paralyzing compounds. It works immediately it is sprayed or applied by absorbing odors by chemical reaction. The base substance is a high molecular, long-chain quaternary ammonium compound having antiseptic, germicidal and bacteriostatic potencies. It can be sprayed into rooms to remove and control odors, applied to dressings to control odors, used to deodorize urinals, drainage bottles and bedpans as well as in all cleaning procedures on floors, carpets, woodwork, garbage pails and other areas. **Thomas A. Edison, Incorporated, Medical Gas Div., P.O. Box 15, Stuyvesant Falls, N. Y.**

For more details circle #433 on mailing card.

Divided Syringe Bag Reduces Breakage

The new steriLine Divided Syringe Bag for sterilizing syringes reduces breakage. The divided bag permits placement of barrel and plunger in separate pockets without touching which cuts down breakage. The bag incorporates the improved indicator ink which is more accurately responsive to sterilizing and stands up better in storage. The ink

is purple in color changing to green upon complete sterilization. **Aseptic-Thermo Indicator Co., 11471 Vanowen St., North Hollywood, Calif.**

For more details circle #434 on mailing card.

WHAT'S NEW

Biological Container Uses Liquid Nitrogen

The new Linde 3X-25 Biological Container needs no mechanical refrigeration

but makes use of liquid nitrogen at minus 320 degrees F. for freezing and storage of biologicals. The container will maintain its low temperature for 30 days without recharging.

The container employs an inner and outer container separated by a special super insulation. It has a capacity of 29 liters of liquid nitrogen and stores six baskets 2¾ inches in diameter and 11 inches long. The unit is of welded steel construction and stands 22 inches high and 17½ inches in diameter. **Linde Air Products Co., 30 E. 42nd, New York 17.**

For more details circle #435 on mailing card.

Shamrock White Expands Azphlex Tile Line

A bright new color has been added to the line of Azphlex Vinylized Tile. It is Shamrock White or P-719, a white background with colorful green marbleizing effect. It is available in nine by nine inch sizes with 3/32, ⅛ and 3/16 inch thicknesses. All Azphlex marbleized and terrazzo tone colors are now available in the above thicknesses. **Azrock Products Div., Uvalde Rock Asphalt Co., 520S Frost Bank Bldg., San Antonio, Tex.**

For more details circle #436 on mailing card.

Nylon Syringes Are Unbreakable

S.E.S.I. Nylon Syringes, long used in Europe, are now available in this country through A.C.D. Hospital Specialties. The new syringes can be autoclaved and are leakproof, interchangeable and unbreakable. They can be boiled or dry autoclaved the same as rubber goods, are completely hygienic and easy to clean. Needles are readily affixed by applying pressure with a twisting motion. The nylon syringes are indelibly marked and offered in two, three, five, ten and twenty cc. sizes. **A.C.D Hospital Specialties Inc., 1393 E. Washington St., Pasadena, Calif.**

For more details circle #437 on mailing card.

Acoustical Tile Is Non-Combustible

With non-combustible qualities, Fresco Acoustical Tile looks like stippled plaster. The rough white finish may be spray-painted to match decorative schemes and is available in 12 by 12 or 12 by 24 inch sizes. Fresco may be installed on a concealed suspension system or adhered directly to the underside of any surface. **Owens-Corning Fiberglas Corp., Toledo 1, Ohio.**

For more details circle #438 on mailing card.

Motion Picture Recording with X-ray Unit

The new Westinghouse Cine-Fluorex x-ray unit incorporates the Fluorex image intensifier with motion picture recording for practical radiological study. A 16 mm film is used with speeds of 15 or 30 frames per second for recording of fast-motion body functions which may then be studied repeatedly. X-rays are generated only when the film is stationary

with the use of the cine control which synchronizes the x-ray beam with the film. A 50 per cent reduction in patient exposure time is achieved.

The Cine-Fluorex unit adapts to modern tables without altering normal fluoroscopic work habits and simultaneous viewing with both eyes is permitted. The Cine-Fluorex stabilizer maintains a constant brightness for uniform film density for any variable in body thickness. **Westinghouse Electric Corp., X-Ray Div., P.O. Box 416, Baltimore, Md.**

For more details circle #439 on mailing card.

Therapeutic Instrument Is Portable

The new Burdick ultrasonic therapeutic unit weighs only 25 pounds and may be transported from room to room. The unit generates sufficient power for all ordinary therapeutic purposes with an output of 15 watts and effective radiating area of six square centimeters. **Burdick Corp., Milton, Wis.**

For more details circle #440 on mailing card.

(Continued on page 216)

Control Packs of Soluble Coffee

G. Washington's Soluble Coffee is now available in special packages for controlled service. The new 4½ ounce package is designed for use in a regular coffee urn and is described as the equivalent of one pound of ground coffee. The 22½ gram package for use in glass coffee makers can be used with regular glass coffee makers for 10 to 12 cups of coffee.

The new Institution H & R G. Washington's 100 Per Cent Pure Soluble Coffee is said to have the advantage of savings in coffee cost, in brewing time and in cleaning time since there are no grounds to clean up. The new coffee is described as offering uniformly excellent cup quality with fresh coffee flavor. **American Home Foods, Institution Products, 22 E. 40th St., New York 16.**

For more details circle #441 on mailing card.

Colost-O-Drain Is Easily Cleaned

A new self-cleaning colostomy irrigator called the Colost-O-Drain has been developed to provide a standard procedure method of colostomy care. The Colost-O-Drain is an absolutely sanitary device which is easy to keep clean under all conditions and holds no odor. The modest first cost with no straps, rings, tubing or bags to replace, make the Colost-O-Drain practical and economical for patient and hospital use.

The Colost-O-Drain rests snugly against the body by means of a loosely fastened belt. As the colon is irrigated, the drainage flows down the discharge chamber into the toilet. The normal procedure for using the device is to be seated upon the toilet in a normal position with the Colost-O-Drain extended into the bowl, although the unit works on the same principle in bed. As drainage occurs, the Colost-O-Drain may be flushed clean as often as necessary with the flushing bulb. After all drainage has passed, the dis-

charge chamber may be emptied, rinsed clean and dried ready for further use. **Trinity Industries, 201 S. Walnut St., Salem, Ill.**

For more details circle #442 on mailing card.

...of all these ELGIN Water Softener features...

- which do you consider most important?

1 DELIVERS UP TO 44% MORE SOFT WATER. The ingenious "Double-Check" manifold system permits a *deeper* zeolite bed, which delivers as much as 44% more soft water than water softeners of conventional design and equal size. No stretching your supply to the danger point!

2 ZEOLITE LOSS PREVENTED. "Double-Check" manifold also prevents loss of expensive zeolite during backwash period. A *real* money saver, with zeolite costs as they are!

3 REQUIRES LESS SPACE. To deliver a soft water output to equal Elgin's, *any* other water softener would have to be 44% bigger. Elgin lets you take advantage of limited space!

4 BETTER BACKWASHING. "Double-Check" design provides better, more thorough backwashing which keeps zeolite clean, active and more receptive to salt regeneration. This assures peak operation year after year!

5 LOWER OPERATING COSTS. Better service means lower costs in the long run! With cleaner, more active zeolite, regeneration takes less salt and wash water.

6 LOWER MAINTENANCE COSTS. Heavy duty construction throughout offers you greater permanence with an Elgin Water Softener. Combine that with the zeolite-saving, more efficient "Double-Check" manifold system, and you get lower overall maintenance costs and added years of service!

7 MORE ECONOMICAL TO BUY. Even though the Elgin Water Softener provides all these outstanding features, when you figure cost per thousand gallons of soft water delivered, lower maintenance cost and time saved, you'll find it your most economical buy.

Elgin offers you a complete line:

MANUAL • PUSH-BUTTON AUTOMATIC • FULLY AUTOMATIC

Equally advanced in design are other Elgin Ion-Exchange Systems which provide Alkalinity Reduction, Deionization, Silica Removal and Hot Zeolite Softening.

Write or call us for further information concerning your water conditioning needs . . . or better still, let us put our near-by representative in touch with you!

ELGIN SOFTENER CORPORATION

144 North Grove Avenue, Elgin, Illinois

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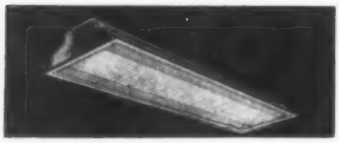
ION EXCHANGERS • FILTERS • DEAERATING HEATERS • DEALKALIZERS • DEGASITORS • LIME SOFTENERS • CHEMICALS

WHAT'S NEW

Recessed Lighting Fits Most Ceiling Systems

Shallower 12 and 24-inch fixtures have been designed to be compatible with 63



different ceiling systems. The integrated Day-Brite recessed lighting is intended for acoustical ceilings using exposed runner, exposed panel, exposed grid, concealed mechanical, metal Tee-Bar suspension and conventional plaster ceilings.

Enclosures for the 12-inch fixtures include plastic Cleartex, egg-crate louver, or low-brightness Controlens with translucent plastic and egg-crate louver or glass available for the 24-inch fixtures. **Day-Brite Lighting, Inc., 5411 Bulwer Ave., St. Louis 7, Mo.**

For more details circle #443 on mailing card.

Gas Sterilizer for Delicate Supplies

The new Castle Sterox-O-Matic Gas Sterilizer safely sterilizes heat and moisture-sensitive hospital supplies too delicate for conventional sterilization. Employing liquified steroxcide gas at temperatures ranging from 70 to 170 degrees F., the

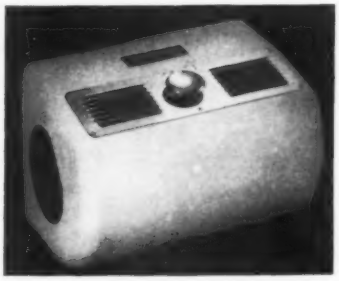
unit is ideal for plastics, adhesives, catheters, powdered goods, electric cords, all types of scoped instruments and other supplies.

Liquified steroxcide gas, a non-combustible mixture of ethylene oxide and carbon dioxide, is a highly concentrated killing agent which penetrates and sterilizes contents of sealed cardboard, polyethylene, polyvinyl or paper containers. The new unit has an automatic push-button operation. **Wilmot Castle Co., Steroxcide Research Dept., Box 629, Rochester 2, N.Y.**

For more details circle #444 on mailing card.

Face and Hand Dryer Serves Two People

Each unit in the new Federal Industrial Series D line of electric hand and face dryers is able to serve two people simultaneously, making the line ideal for



heavy traffic locations. A unique construction feature delivers an efficient air flow through a pair of louvered grills for drying hands and face in one operation.

Model DB-200, illustrated, is constructed of an easily removable cast aluminum one-piece cover which is available in a choice of colors and white. The unit is guaranteed vandalproof by the manufacturer, according to the report. **Federal Industrial Mfg. Co., 3109 Forbes St., Pittsburgh 13, Pa.**

For more details circle #445 on mailing card.

(Continued on page 218)

How to simplify and cut costs of Your wall construction with

BAYLEY
CURTAIN WALL SYSTEMS

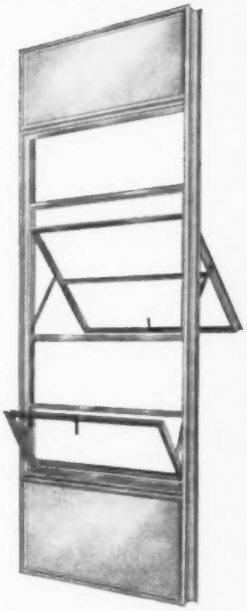
After Curtain-Wall is installed. Before Curtain-Wall is installed.

—incorporating BAYLEY Projected Windows and Decorative Panels

Bayley Curtain Wall Systems—in either aluminum or steel—offer you the maximum economies to be realized from modern curtain-wall construction. Incorporating standard time-proved Bayley Projected Window Units, and a Bayley system of sub-frame assembly, a designer's preference can be met without the costliness of special window designing. Also, as illustrated, installation is reduced to the simplest procedure. Other advantages accruing are:

- ✓ **Permits a choice of decorative panels and individualized arrangements**
- ✓ **Provides an insulated wall treatment to suit the building's appropriation**
- ✓ **Designed to accommodate a building's movement — expansion and contraction**
- ✓ **Provision against condensation annoyance or damage**
- ✓ **A wall with any desired degree of air, light or vision**
- ✓ **Centralized responsibility for the complete wall system — including sub-frames, windows and panels**

For further information write; or call your local Bayley Representative; or see Sweets.



The Bayley Series A-450 Aluminum Curtain-Wall Unit.

Write Today for this Curtain-Wall Idea File.

1. Bolting sill and header plate into position.
2. Bolting jamb plate to load-bearing column.

3. Interlocking window-panel into position.

4. Caulking interlock grooves before positioning mullion.
5. Positioning Bayley adjustable-width mullion.
6. Positioning window-panel — using interlock groove as slide.

THE WILLIAM BAYLEY COMPANY

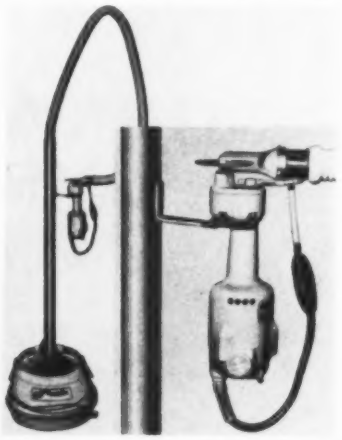
Springfield, Ohio

District Sales Offices: Springfield Chicago 2 New York 17 Washington 16

WHAT'S NEW

PlasterVac Eliminates Cast Dust

The new Stryker PlasterVac heavy duty vacuum unit has been designed for use with the Stryker Cast Cutter. The



unit quickly and efficiently draws away all plaster dust as the cast is being cut. The plastic PlasterVac hose is internally supported to prevent "drag" on the cutter while in operation. The unit is not readily tipped while in operation and the vacuum withstands lengthy operation without mechanical failure. Disposable cleaner bags are available for each unit. PlasterVac is available with or without the cutter. **Orthopedic Frame Co., 420 Alcott St., Kalamazoo, Mich.**

For more details circle #446 on mailing card.

Scintillation Detector for Radioactive Samples

Model DS-3 Scintillation Well Counter has wide medical application for blood and plasma volume studies, measurement of red cell mass, protein bound iodine levels and pernicious anemia diagnosis. The compact instrument features a large sodium iodine well crystal into which a test tube or centrifuge tube can be placed for measurement of gamma emitting radioactive samples. Only minimum amount of radioactivity need be present for accurate, rapid measurement. The model may also be used with gamma-ray spectrometer systems. **Nuclear Instrument and Chemical Corp., 229 W. Erie St., Chicago 10.**

For more details circle #447 on mailing card.

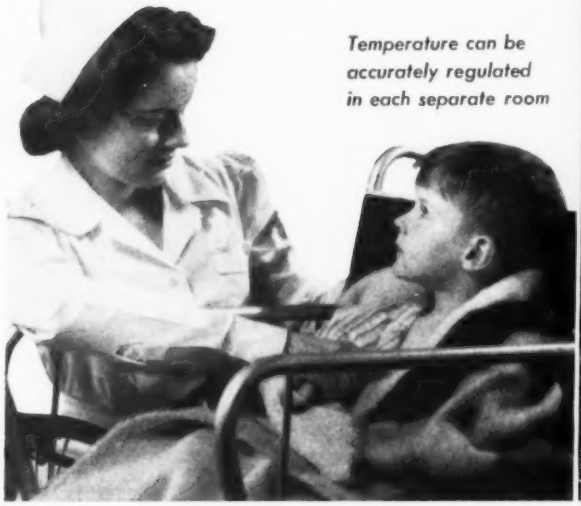
Light Fixture for Sloped Ceilings

Vertical downlighting in sloped ceilings is easy to achieve with the new Versen Parflex fixture. The unit is engineered for easy installation in slopes up to 15 degrees and the detachable yoke assures perfect, plumb mounting and flush ceiling fit without any visible screws. **Kurt Versen Co., Englewood, N.J.**

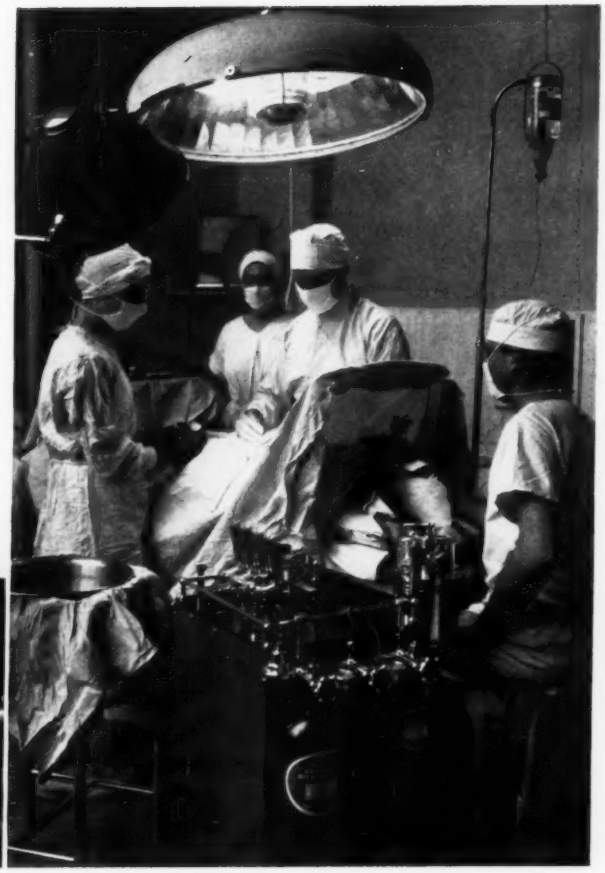
For more details circle #448 on mailing card.

(Continued on page 220)

IRON FIREMAN SelecTemp® HEATING



Temperature can be accurately regulated in each separate room

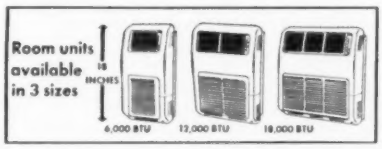


The revolutionary new heating system with a thermostat in every room

With SelecTemp, the new, yet proved method of modern heating, the temperature of *each* room can be regulated to fit the patient's needs, day and night. Each special room—nursery, surgery, recovery rooms—can be held at the temperature desired. The selected temperature is uniform throughout the room, with a gentle, steady circulation of clean, filtered air. Each room is its own heating zone with responsive thermostatic control, providing real comfort and proper individual care for each patient.

Safe in operating rooms and laboratories. Each steam operated room unit contains a filter, an air circulating fan and an individual thermostat. Both fan and thermostat are non-electric. Since no electricity is used, SelecTemp units are spark-free and safe in rooms where inflammable gases are present.

Easy and economical to install. In new construction or modernization, the SelecTemp system can be quickly installed at a cost that is no greater than many systems which do not provide the many SelecTemp advantages. Some hospitals have first replaced steam radiators with SelecTemp units in a limited number of rooms, and have later extended the system throughout the building. In addition, SelecTemp heating is being specified for new additions.



No overheating—low operating costs. When a window is opened to cool an overheated room, costly fuel is wasted. This waste is avoided with SelecTemp heating. Heat can be reduced in rooms temporarily not occupied. Such rooms can be quickly reheated when needed. Users report substantial savings in fuel bills.

For cooling. Individual unit cooling, with SelecTemp heating, makes the perfect all-year combination for patient and employee comfort, and for low cost operation.

Send for free literature on the SelecTemp heating system. Use coupon below.

IRON FIREMAN®
Engineered
HEATING & COOLING

IRON FIREMAN MANUFACTURING CO.
3410 West 106th Street, Cleveland 11, Ohio
(In Canada write to 80 Ward Street, Toronto)

☐ Please send more information on SelecTemp heating.
☐ Arrange for brief demonstration of SelecTemp room unit, in actual operation, in our office.

Name_____
Hospital_____
Address_____
City_____ Zone____ State_____

Flex-Straws Packed in Dispenser

All unwrapped Flex-Straws are now shipped in a new dispenser box for convenient and sanitary dispensing of the straws. A pull-tab opener permits serving one or more drinking tubes without touching either end of the straw. The tab can be closed between uses assuring added sanitation. Each box contains 500 Flex-Straws and replaces the regular top-opening box for unwrapped straws. **Flex-Straw Co., 2040 Broadway, Santa Monica, Calif.**

For more details circle #449 on mailing card.

Micro Opaque Reader Accepts Any Micro Data

Micro data cards up to nine inches in one dimension and unlimited in the other are easily placed in position and moved from frame to frame with the new AO Micro Opaque Reader. Material faces up in plain view of the operator on the opaque reading screen which offers eye-reading comfort. The large screen is 11 by 12⅝ inches and has a 15 degree comfortable reading angle.

Other features of the reader include three easily interchangeable objectives, focus knob adjacent to operator, off-on finger tip switch and foot switch available for photocopy timing. A cast steel frame for optics assures permanent optical alignment and fan cooling prevents heat damage to cards. The unit is finished in two-tone gray and charcoal baked-on enamel. **American Optical Co., Instrument Div., Buffalo 15, N.Y.**

For more details circle #450 on mailing card.

(Continued on page 222)

This close-up of a 9" x 9" tile is typical of the beautiful, soft marbleizing found only in Kentile rubber tile.

the extraordinary resilience and long wear of KENTILE® rubber tile is your best answer!

Every hospital deserves the restful atmosphere and cushioned beauty of Kentile rubber tile in rooms, corridors, and wards alike. Patients appreciate its cheerful colors and smart designs. Doctors and nurses welcome the fact it helps reduce fatigue. And hospital attendants find Kentile rubber tile is so easy to keep clean. Its pre-polished surface resists dirt and stains, and because it's so exceptionally tough, floors look like new even after years of hard wear. Yet Kentile rubber tile requires minimum maintenance and expense. For complete details, just get in touch with your Kentile flooring contractor. He's listed under FLOORS in your Classified Telephone Directory.

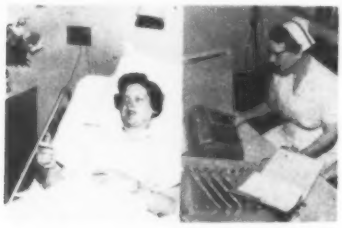
KENTILE FLOORS BROOKLYN 15, N. Y.

AVAILABLE IN • RUBBER • CORK • VINYL ASBESTOS • SOLID VINYL • CUSHION-BACK VINYL • AND ASPHALT TILE . . . OVER 150 DECORATOR COLORS

WHAT'S NEW

Nurses' Call System Has Multiple Channels

The new DuKane Multi-Channel Call System incorporates the use of two or



more master stations strategically located on the floor. This installation lightens the nurse's work load as she need not return to the centrally located master station to answer a call. Two separate calls may be answered simultaneously at two master stations.

When the patient registers a call, the corridor light goes on, a key lights up at all masters on the floor and a soft tone sounds at 10 second intervals until the call is answered on any master. A "call" light at the bedside assures the patient that his call has been registered.

Selecting the calling station at any master connects the patient for conversation and extinguishes the key light at all masters. Emergency lights register at all masters and are indicated by flashing corridor lights and must be cancelled at patient location. A busy "buzz" is audible to other masters should they select the same bedside stations. **DuKane Corporation, St. Charles, Ill.**

For more details circle #451 on mailing card.

Instant Nonfat Dry Milk in Institutional Container

A new cardboard container with a special inner wrapper which protects the milk powder from moisture is now available for Instant Pet Nonfat Dry Milk for institutional use. The large package features economy of packaging and filling, reducing the cost per quart of reconstituted nonfat milk. The fold-open inner wrapper makes the package easy to use and produces a moisture-proof package equal to glass, according to government tests. The new size, for 12 quarts of reconstituted nonfat milk, produces milk of the same fresh flavor with all protein, calcium and B vitamins of fresh milk with instant mixing. **Pet Milk Co., 1401 Arcade Bldg., St. Louis 1, Mo.**

For more details circle #452 on mailing card.

Urine Test Tape from Vending Machine

A vending machine has been designed to make a new urine sugar test tape readily available to hospital personnel and visitors. The initial low cost of the unit not only assures a profitable venture for the institution, as each package is vended for twenty-five cents, but also provides an inexpensive diabetes check for the public.

The machine dispenses a complete package including the hermetically sealed Sugar-Chek Test and a comprehensive diabetes information folder. Complete instructions on how to use the Sugar-Chek and how to interpret the results is given on the outside of the package. The Sugar-Chek is a practical device to encourage the public to determine privately

and at their convenience if glucose is present in the urine. **Clinical Development Laboratories, 2600 S. Walnut St., Springfield, Ill.**

For more details circle #453 on mailing card.

(Continued on page 224)

four forms of the widely accepted local and topical anesthetic

Xylocaine HCl Injectable Solution—A fast-acting local anesthetic—as safe as it is effective. Xylocaine produces more rapid, complete and deeper anesthesia than other local anesthetics used in equivalent doses. In addition, its topical anesthetic properties further enhance its usefulness.

Available: Vials, 0.5%, 1% and 2% in 20 cc. and 50 cc. without and with epinephrine 1:100,000; 100 cc. vials, 1% without epinephrine. Ampoules, 2 cc., 2% without and with epinephrine 1:100,000.

XYLOCAINE® ASTRA

(Brand of lidocaine*)

Xylocaine Ointment—Water Soluble and Nonstaining—For rapid acting, profound surface anesthesia. Available as a 2.5% and 5% ointment in collapsible tubes (5% also available in wide-mouth jars) each containing 35 grams (approx. 1.25 ounces).

Xylocaine Jelly—Water Soluble and Sterile—For instant, deep anesthesia of accessible mucous membranes. Useful in procedures involving the genito-urinary tract, the ear, nose and throat. Contains 2% Xylocaine Hydrochloride, supplied in collapsible tubes, each tube delivering at least 30 cc.

Xylocaine Viscous—The most effective orally administered surface anesthetic available for use in proximal parts of the digestive tract. Contains 2% Xylocaine Hydrochloride in a cherry-flavored base. Supplied in bottles of 100 and 450 cc.

Be sure your stocks are adequate to meet the demand of physicians on all forms of Xylocaine Astra.

Astra Pharmaceutical Products, Inc.
Worcester 6, Mass., U.S.A.

ASTRA

*U. S. PATENT NO. 2,441,498

WHAT'S NEW

Liquid Porcelain Cleaner in Applicator Bottle

An unbreakable polyethylene bottle with attachable sponge rubber applicator is now available with Brulin's Bowlette liquid compound for cleaning porcelain and vitreous ware. The new container is designed for easy handling. With the "Sponge-Spout" attached, Bowlette is dispensed by simply inverting the bottle over toilets and urinals and swabbing with the applicator. Waste is minimized and it is not necessary for the worker's hands to come in contact with the cleaning compound. Regular use of Bowlette is said to keep toilet fixtures clean and free from odor-causing bacteria. **Brulin & Co., Inc., 2939 Columbia Ave., Indianapolis 7, Ind.**

For more details circle #454 on mailing card.

Paper Towel Is Highly Absorbent

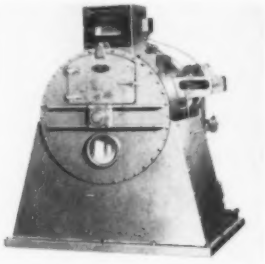
The new Scott Ultra High Absorbency Paper Towel has a contoured surface appearance which resembles fine cloth. The stippled surface provides greater

porosity, bulk and thickness which absorb water quickly. Chemicals added to the paper pulp during processing produces a high wet strength which allow the towel to be used without tearing or shredding. Towel consumption is reduced as only one Scott towel is usually needed to dry face and hands. The No. 151 towel measures 10-7/16 by 14 inches and is packaged 150 towels to a board sleeve. **Scott Paper Co., Chester, Pa.**

For more details circle #455 on mailing card.

Fully Automatic Operation for Washer-Extractor

The Glover Auto Feeder is a compact washer-extractor, occupying only 465 feet of floor space. The 60-pound, fully automatic unit is simple to operate, requiring only a few minutes of the operator's time



to load the machine and add the first suds through the soap chute. The operator is then free for other duties while the machine completes the washing and extracting cycle.

Glover Auto Trol controls are fully automatic, eliminating possibilities of human error in washing, rinsing and extracting. The two-pocket type machine permits loading of the wash equally into each pocket for perfect cylinder balance. Quality wash for each load is assured by the automatic controls. **The Bill Glover Co., 5204 Truman Rd., Kansas City 27, Mo.**

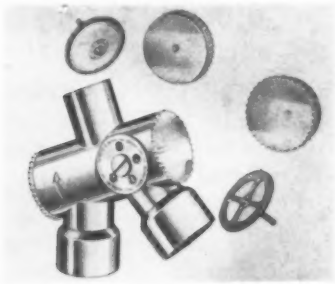
For more details circle #456 on mailing card.

(Continued on page 226)

WHAT'S NEW

Y-Valve Is Non-Reversible

The new Sierra Y-Valve is an absolutely safe, non-rebreathing instrument



which operates at the fingertips of the anesthesiologist. It employs a built-in system of non-reversible check valves which vary slightly in size so that it is impossible to accidentally reverse their positions. The free-floating valves cannot stick and their action during operation can be observed through transparent plastic screw-on caps located at each end of the valve cells.

An exhaust port on the exhalation side of the body to prevent dilution of anesthetic gases is fully adjustable between full-open and closed positions. Accumulation of moisture within the instrument will not affect the action of the check valves. Valves of silicone rubber diaphragms on lightweight metal may be sterilized in any suitable solution and the body of the instrument may be autoclaved. **Sierra Engineering Co., 123 E. Montecito Ave., Sierra Madre, Calif.**

For more details circle #457 on mailing card.

Infant Restraining Tray for Circumcisions

The problem of restraining and immobilizing babies for circumcisions, transfusions and x-rays has been solved by the new Ivanhoe Infant Restraining Tray.

The unit holds any baby from four and one-half to 10½ pounds gently but firmly without pressure. Designed by a pediatrician after years of study, the baby need only be placed on the tray and the restrainer fastened with two screws. The tray is constructed of heavy duty Styron which is easily cleaned with soap and water. X-rays will penetrate through the unit without distortion. **Ivanhoe Enterprises, Inc., 111 Cathedral Ave., Hempstead, L.I., N.Y.**

For more details circle #458 on mailing card.

Whole Milk Powder Dissolves Instantly

Snowflake whole milk powder dissolves instantly in hot water for immediate use or may be chilled for drinking. The reconstituted product tastes and cooks like fresh homogenized milk. Snowflake is available in four pound cans which will make 16 quarts of whole fluid milk. **Webster Van Winkle Corp., 99 Summit Ave., Summit, N. J.**

For more details circle #459 on mailing card.

Library Furniture for Institutional Use

Standard Wood Products has introduced the new Donnell line of library furniture for heavy duty use in hospital libraries and other institutions. The line is constructed of naturally finished wood which is functional and attractive.

Pieces in the line include charging desk units, card catalog files, library shelving, tables and chairs and miscellaneous units such as stools, stands and racks. Each piece is offered in various models to meet the requirements of any institutional need. **Standard Wood Products Corp., Library Div., 47 W. 63rd St., New York 23.**

For more details circle #460 on mailing card.

Flexible Armofoam for Upholstered Seating

A new cushion foam for padding under upholstery for folding chairs, lobby and patient room seating and similar uses is offered in Armofoam. A flexible polyurethane foam, all raw materials are produced within the United States.

Armofoam is odorless and flame-resistant, can be washed or dry cleaned, and resists solvents, abrasion, vermin, sliding and fabric creep. It is extremely durable with strength increased by aging, and is the result of more than two years of exhaustive research and laboratory tests. **Armour and Company, Alliance, Ohio.**

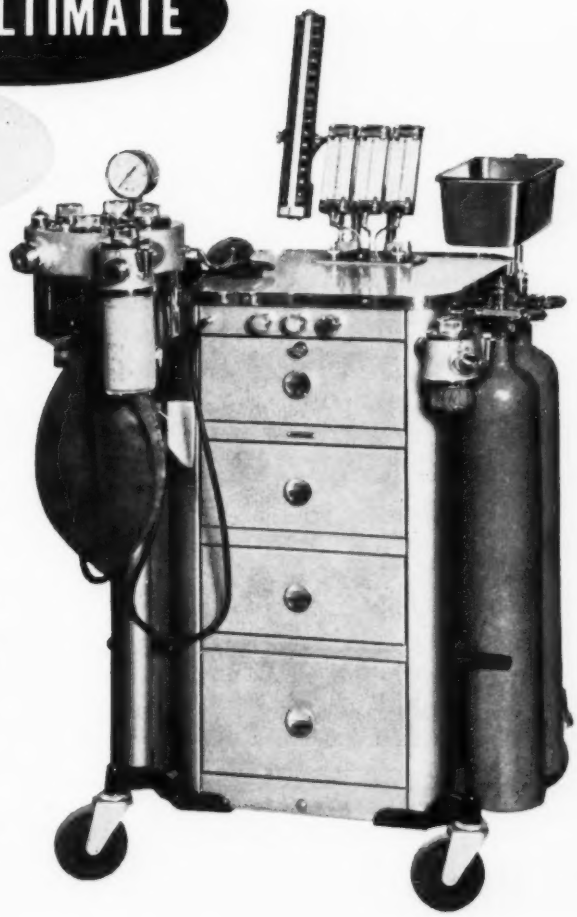
For more details circle #461 on mailing card.

(Continued on page 228)

THE ULTIMATE

in modern anesthesia equipment

NEW McKESSON CABINET MODEL



- Supplied with any combination of gases now in use.
- Equipped with bi-phase flow meters.
- Flow-rate controls mounted on front for utmost operating convenience.
- Twin Canister Absorber with 1800-gram baralyme capacity.
- Bag-Pressure Gauge shows pressure of gases in circuit at all times.
- Direct Oxygen Button for immediate oxygen under pressure.
- Direct Nitrous-Oxide Button for quick refilling of nitrous bag.
- Large storage capacity in four locking drawers.
- Stainless steel top and heavyweight steel construction.
- Finished in green enamel, trimmed with chrome-plated parts.
- Supplied with wide variety of accessories.

McKesson

NEW CABINET MODEL

For prices, other features and full details, write for McKesson Cabinet Model literature.

McKESSON APPLIANCE COMPANY • TOLEDO 10, OHIO

WHAT'S NEW

Folding Steel Door Allows Ventilation

The new Fenestra folding steel doors are louvered to permit full ventilation

even when doors are closed. Ideal for closets and storage areas, the doors are easily installed and can be painted to match room colors. The doors fold back to jambs for full access to the storage area, yet take up little floor space.

Construction features of the new line include ample clearance, non-sagging or warping, quiet operation, maximum service life, no jumping off track and no maintenance. The doors are available in six feet eight inches and eight feet heights, in widths to meet most requirements. **Fenestra Inc., 3255 Griffin St., Detroit 11, Mich.**

For more details circle #462 on mailing card

Anti-Slip Floor Wax Is Self-Polishing

Super Anti-Slip Safety Floor Wax is a liquid self-polishing product applicable to all types of floors. The Simoniz additive, Ladium, combines maximum slip resistance with long wear and high gloss qualities. Floors finished with the new wax can be repeatedly damp mopped because of the high resistance to water. Luster is easily restored by buffing. The new product does not leave stain or build-up and stripping is quick and easy. Minimum maintenance with a safe surface are features claimed for the new product. **Simoniz Company, Commercial Products Div., 2100 Indiana Ave., Chicago 16.**

For more details circle #463 on mailing card.

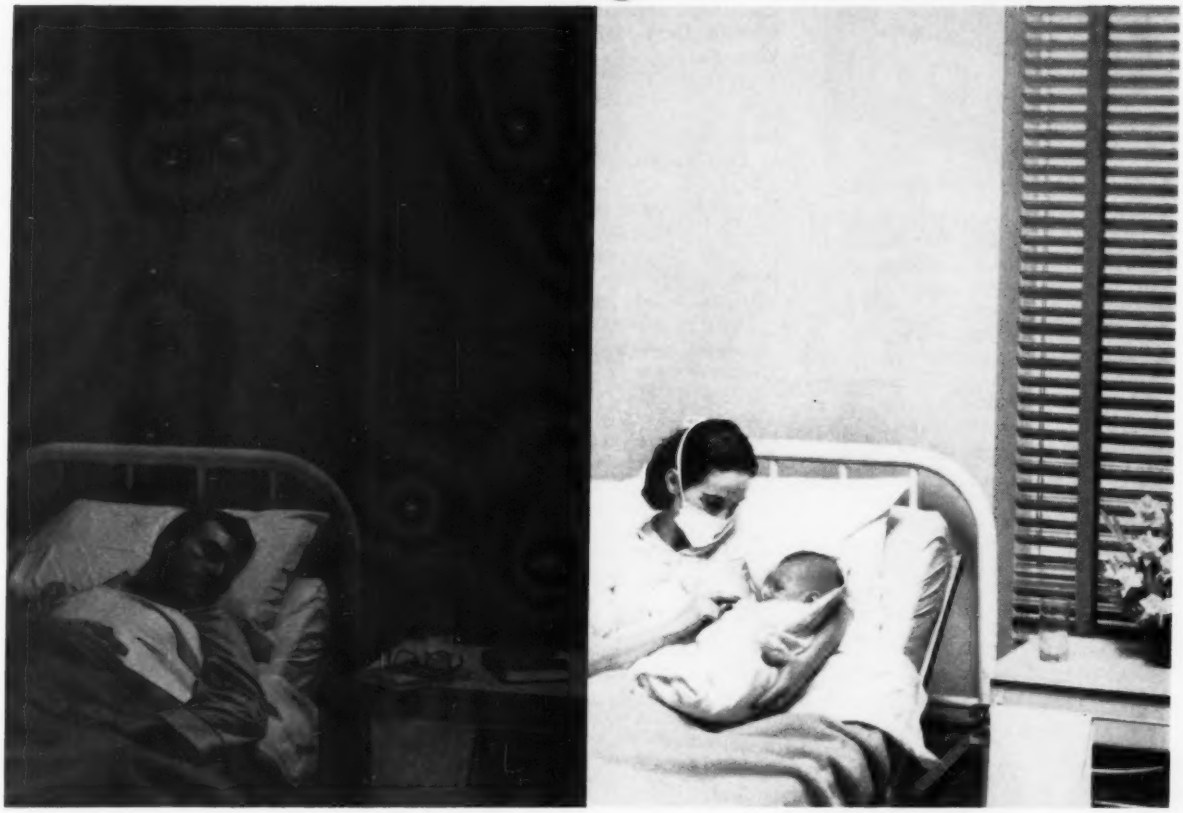
Custom-Built Incinerators Meet Every Need

Winnen's new line of custom-built incinerators are built to any size to fill individual requirements. The units are built to pass smoke-abatement codes everywhere and will withstand temperatures exceeding 2500 degrees F. Optional equipment includes automatic firing control, pre-fab chimneys, over-fire burners and electronic controls. There is a choice of three different door types. **Winnen Incinerator Co., 932 Broadway, Bedford 32, Ohio.**

For more details circle #464 on mailing card.

(Continued on page 230)

why hospitals choose new *Flexalum* Twi-Nighter® Venetian Blinds



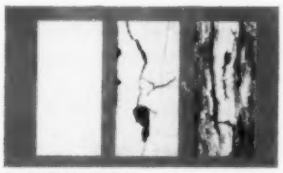
give complete light control

Now patients can rest comfortably in the daylight hours too. Twi-Nighter blinds make rooms not just dim – but dark! Keep out 6 times more daylight because of Flexalum's new shut-tight design. Light leakage is eliminated – privacy is assured. (Tests by U.S. Testing Laboratories.)

easy to keep sanitary

Flexalum wipe-clean plastic tapes have no loose fibers, no porous openings to absorb dirt or bacteria. And they won't fade, fray, shrink or stretch. Spring-tempered aluminum slats have exclusive baked-enamel finish with permanent hard wax surface that's easier to keep clean.

LIGHTMETER TEST proves tighter closure. Under identical conditions, lightmeter probes measured light intensity: for standard blind 5.2 foot candles; for the Twi-Nighter only .85 foot candles.



SALT SPRAY TEST shows how Flexalum slats stay clean and new-looking for years. Flexalum slat (at left) looks unchanged after 500 hours exposure to salt spray. Others exposed only 375 hours.

BACTERIA TEST demonstrates that under identical test conditions fabric tape picked up over 700,000 bacteria per square inch. Flexalum plastic tape picked up only 100 bacteria per square inch.

Write today for free literature, or for the name of your nearest Flexalum dealer who will be happy to discuss hospital prices with you.

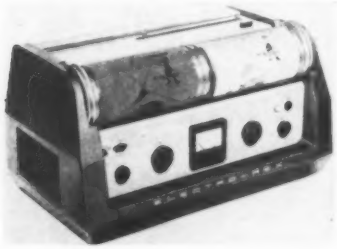
Guaranteed by Good Housekeeping

Hunter Douglas Aluminum Corp., Dept. MH, 405 Lexington Ave., New York 17, N. Y.

WHAT'S NEW

Electronic Stencil Cutter Reproduces Art Work

Stencils or plates can be made from practically any graphic material with the



new Electro-Rex Electronic Stencil Cutter. Almost anything can be printed without the assistance of artist or printer with the new device, according to the report. Stencils of drawings, office forms, typed matter, original layouts, clippings or screened photographs are quickly produced, ready for reproduction.

The optical scanning system in the Electro-Rex process picks up any images placed on the scanning side of the drum. These images are converted to high frequency currents and through electronic amplification are transferred to a cutting stylus on the reproduction side of the drum. An exact duplicate of the original is thus obtained on a plastic stencil or a plate, ready for immediate duplication of thousands of copies of high quality.

Scanning definition from 125 to 750 lines per inch and sensitivity variable over the entire tone scale from black to white assure high quality reproductions. Electro-Rex Stencils may be used with any stencil duplicator. **Rex-Rotary Distribution Corp., 387 Fourth Ave., New York 16.**

For more details circle #465 on mailing card.

Fruit Dessert Mix in Low-Moisture Pack

Sun-ripened fruits are processed by the Vacu-Dry system and packed for institutional use. The new Fruit Dessert Mix contains peaches, apricots, apples, pears and enough Maraschino cherry halves to include one in each portion.

The new mix is offered in low-moisture form and is quickly re-constituted for use, with full flavor. The low-moisture preparation preserves flavor, nutrition and color while reducing shipping costs because of reduced weight, therefore making the product less expensive at point of use. The mix is suitable for use in fruit gelatin desserts or salads, as fruit compote, for cake and ice cream toppings and in many other forms. **Vacu-Dry Company, 950 56th St., Oakland 8, Calif.**

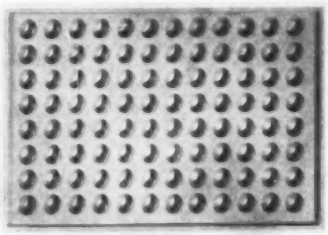
For more details circle #466 on mailing card.

(Continued on page 232)

Disposable Trays for Lab Titrations

The new Linbro Disposo-Tray has been designed to speed up laboratory work by eliminating the need of washing test tubes. There are 96 cups in each tray which hold approximately two c.c. They are used in the same manner as a rack of test tubes in assaying virus, measuring antibodies in tissue culture, serial dilutions and many types of spot tests.

The eight by 12 inch trays are made of white plastic which is inert, non-toxic and resistant to alcohols, acids and alkalies. They do not inhibit the growth of cells or microorganisms. Disposo-trays may be disinfected by rinsing in 70 per cent alcohol or exposure to ultra violet



light for brief periods. Cups may be sealed with heavy mineral oil to prevent evaporation. **Linbro Chemical Co., Inc., 681 Dixwell Ave., New Haven 11, Conn.**

For more details circle #467 on mailing card.

3 reasons why...

FORT HOWARD PAPER TOWELS

belong in every up-to-date washroom

"Little things affect peoples' attitude toward you"

1

CONTROLLED WET STRENGTH

keeps wet towels strong, firm, soft. One towel soaks up all the water on a pair of dripping hands.

2

STABILIZED ABSORBENCY

helps keep this drying power as the towels age. They're good to the last towel in the package.

3

ACID FREE

makes Fort Howard Towels gentle on even the most delicate hands.

These are important qualities in a paper towel. They help dry all hands better, more economically, with greater user satisfaction.

These are the reasons why . . . from factories to offices, from institutions to schools . . . Fort Howard Towels belong in every up-to-date washroom.

Select one of Fort Howard's 27 grades and folds for your washroom. Remember—Fort Howard Towels can fill any cabinet at any price. Call your Fort Howard distributor salesman for more information and samples... or write Fort Howard Paper Company, Green Bay, Wisconsin.

Fort Howard Paper Company

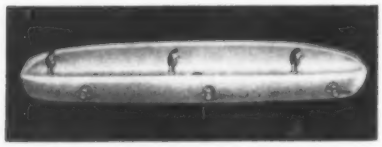
Green Bay, Wisconsin

"America's most complete line of paper towels, tissues and napkins"

WHAT'S NEW

Multiple Drinking Fountain in Attractive Colors

Modern design, cheerful colors and lightweight yet strong Fiberglas construc-



tion are features of the new Haws drinking fountain. Designed by Channing Wallace Gilson, the fountain has flowing contour lines which harmonize with any style of architecture. The new model is wall mounted, has three bubblers and includes all Haws sanitation features in its construction. The three angle-stream fountain heads are raised and shielded to prevent direct mouth contact and are vandalproof-mounted to the receptor.

Fiberglas plastic used in the fountain is exceptionally strong and designed to withstand severe abuse. Its light weight facilitates installation and requires minimum support. The new drinking fountain is available in white and in five decorator colors: Cerulean, Pistachio, Coral Accent, Yellow Mist and Grey Satin. **Haws Drinking Faucet Co., Fourth & Page Sts., Berkeley 10, Calif.**

For more details circle #468 on mailing card.

Color TV Camera for Medical Use

RCA has designed a compatible color television system for live closed-circuit or on-air colorcasts of surgical, medical, and instruction and demonstrations for use

by hospitals, medical centers and other institutions. The TV camera is designed for horizontal installation in an overhead fixture which supports both camera and surgical lamp. The camera peers into a mirror which reflects the optical path downward through an opening in the surgical lamp. The mirror can be panned and tilted to change viewing field without moving camera or lamp. If lamp is moved, camera automatically coincides with change.

The camera measures 26 by 15 by 14 inches and weighs less than 200 pounds and is designed for permanent installation in the overhead fixture. It permits long periods of exposure to a single scene without image burn-in or halo. A lens turret accommodates four lenses for long, medium, short and close-up viewing. The camera may also be incorporated into a microscope system for direct televising of microscopic specimens. **Radio Corporation of America, 30 Rockefeller Plaza, New York 20.**

For more details circle #469 on mailing card.

Papaya Nectar Base Offers Taste Variety

Between-meal beverages as well as those served with meals can be varied with the use of Papaya-Vita, a new papaya nectar base now available in quart cans. The base, when diluted, makes one gallon of the tropical drink. The nectar is made from the natural juices and pulp of specially hybridized fruit. It is packed in cans, with no preservatives or coloring, and requires no refrigeration until mixed. **Stevens Tropical Plantation, Okeechobee Road, West Palm Beach, Fla.**

For more details circle #470 on mailing card.

(Continued on page 234)

THEY'RE PLANNING A HOSPITAL

NEW COLOR FILMSTRIP SHOWS HOW ALOE EQUIPMENT PLANNING SERVICE CAN SIMPLIFY YOUR EQUIPMENT PLANNING

Whether you are building, remodeling or refurnishing, in just 20 minutes this new Aloe filmstrip will simplify your task. In full color, it quickly explains how other leading hospitals have taken advantage of the *complete* Aloe Equipment Planning Service to insure the most in efficiency, utility and colorful beauty, at lower cost.

The filmstrip describes in detail the systematic, coordinated plan of assistance that Aloe offers from the beginning of your program, with sustained service following completion. Backed by experience in equipping over 400 new hospitals, Aloe can relieve you of many of the details of planning your equipment requirements.

Mail the convenient coupon today to reserve a showing date, without cost or obligation, of course. Available to administrators, architects, hospital boards, and consultants.

A. S. ALOE COMPANY
14 FULLY STOCKED DIVISIONS COAST-TO-COAST

1831 OLIVE ST.
ST. LOUIS, MO.

Equipment Planning Service
Dept. 105
A. S. Aloe Company
1831 Olive Street, St. Louis 3, Missouri
We would like to see your new color filmstrip:

_____
(place) (time) (hour)

Name_____

Title_____

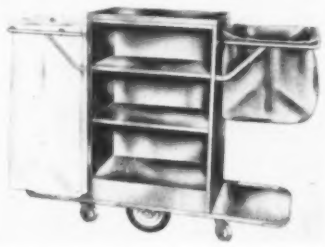
Hospital_____

Street_____

City & Zone_____ State_____

Linen Handling Truck Has Maintenance Platform

Three broad shelves for clean linen and white or khaki canvas bags for



soiled linen and trash, as well as platforms for maintenance equipment and supplies make the new Linen Master No. 56 E 146 a versatile unit. The 27 by 18 inch shelves hold linen supplies for 25 beds. Canvas bags for handling soiled linen and trash are available in a choice of six styles. Khaki bags are flame and water resistant. The tubular steel push handles at each end of the cart have rounded corners for ease of handling. Twin steel doors are available to protect contents of the shelves from dust and pilferage if desired.

Two 16 by 21 inch heavily braced platforms are provided for holding pails, cleaners, trash cans or sweepers. A side rack holds brooms and mops and the cabinet top carries supplies. Two ten-inch ball bearing wheels and four ball bearing rubber tired swivel casters make the truck easy to maneuver. Its 21-inch width permits easy passage through narrow doorways. **The Paul O. Young Co., Line Lexington, Pa.**

For more details circle #471 on mailing card.

Spirit Duplicators in Five Sizes

Developed in Italy, the Duplicarbo Spirit Duplicator is now being made

available in the United States and Canada. Five models, for manual or electric operation, in three sizes, are offered. The electric models offer either single sheet or continuous automatic feeding. The models feature fluid control, pressure dial, accurate registration with reset counter, precision geared pump, automatic master clamp and other facilities. The die cast frames are of duraluminum. **Du Prints, Inc., 1502 S. Main St., Los Angeles 15, Calif.**

For more details circle #472 on mailing card.

(Continued on page 236)

NOW—Flush mounted or Exposed outlets for medical gases

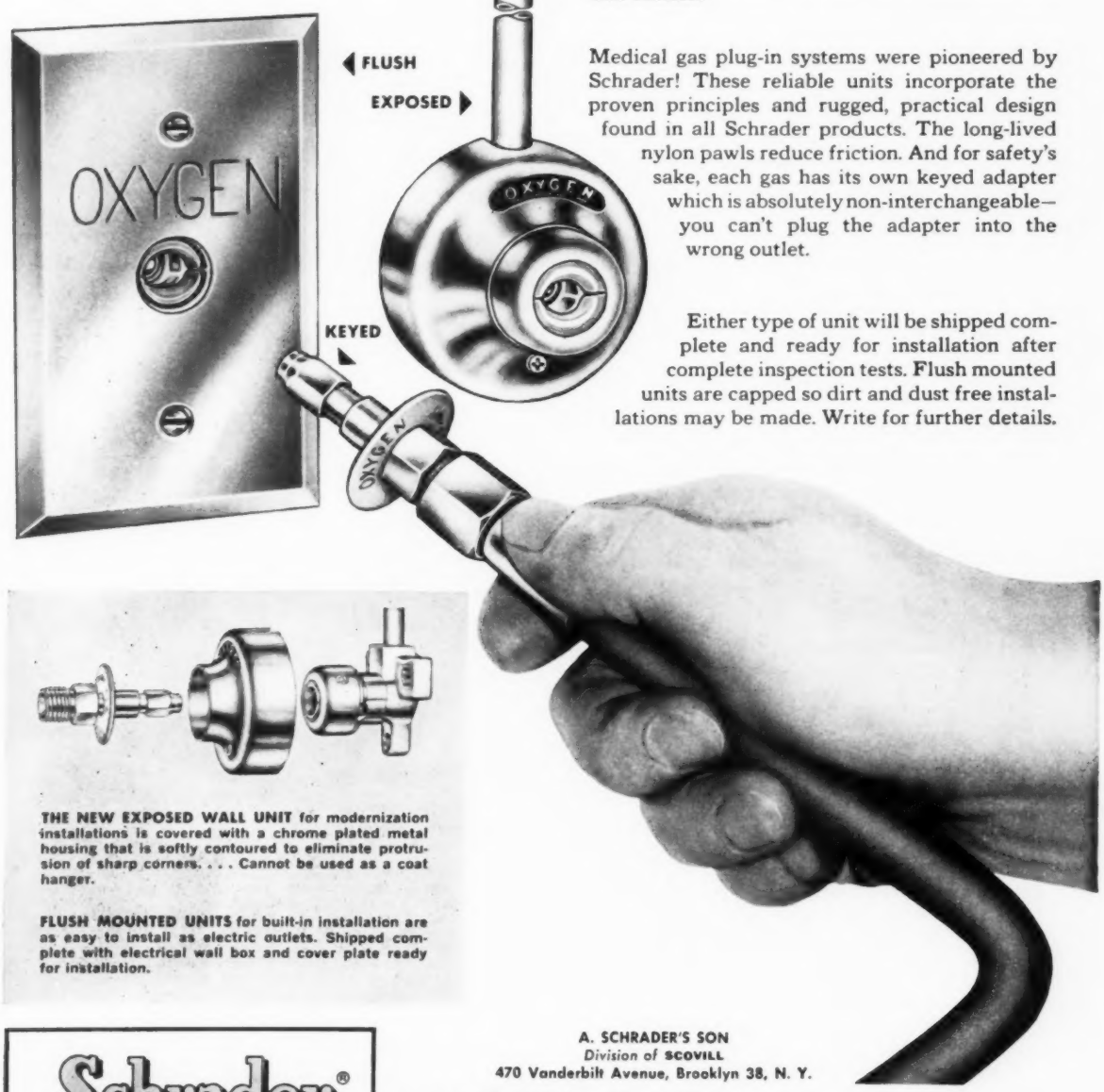
AVOID TRAGIC ERRORS

Schrader safety-keyed adapters for oxygen, nitrous oxide, vacuum and air are absolutely non-interchangeable – you can't plug the adapter into the wrong outlet. For added safety, each outlet is color-keyed for the gas handled.

Now every hospital can take advantage of the Schrader medical gas outlets that combine more features of convenience and safety than any other unit. The interior and working parts of the two types are identical. These are the new outlets that can be coupled and uncoupled by a single-handed operation. Just plug in lines, or disconnect, with one motion.

Medical gas plug-in systems were pioneered by Schrader! These reliable units incorporate the proven principles and rugged, practical design found in all Schrader products. The long-lived nylon pawls reduce friction. And for safety's sake, each gas has its own keyed adapter which is absolutely non-interchangeable—you can't plug the adapter into the wrong outlet.

Either type of unit will be shipped complete and ready for installation after complete inspection tests. Flush mounted units are capped so dirt and dust free installations may be made. Write for further details.



THE NEW EXPOSED WALL UNIT for modernization installations is covered with a chrome plated metal housing that is softly contoured to eliminate protrusion of sharp corners. . . . Cannot be used as a coat hanger.

FLUSH MOUNTED UNITS for built-in installation are as easy to install as electric outlets. Shipped complete with electrical wall box and cover plate ready for installation.

Schrader®
ESTABLISHED IN 1844

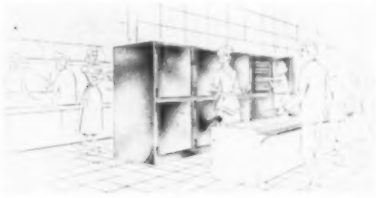
A. SCHRADER'S SON
Division of SCOVILL
470 Vanderbilt Avenue, Brooklyn 38, N. Y.

FIRST NAME IN SAFEST
MEDICAL GAS CONTROL OUTLETS

WHAT'S NEW

Storage Units Handle Hot and Cold Foods

Food service is speeded with the use of McCall TherMcCold Hot 'N Cold Food



Banks. Both hot and cold foods can be prepared well in advance of meal hours and stored, ready for immediate use at serving time. The units are available in pass-through or wall bank models, for large installations serving thousands or for small institutions.

Model TH70 is a six-door unit with two-thirds cold and one-third hot food space. Two units can be used together if required, one completely hot and the other completely cold. Within the hot unit, partitions separate meat and rolls with a separate thermostatic temperature control adjustment. A freezer section can be added if desired. Model TH96 has four sections which can be divided between hot and cold as required. Wall bank models offer similar food sections without the pass-through feature. Cabinets of all models are of all-metal construction with exterior finishes of stainless steel or white Dulux and interiors of stainless steel. Milk containers can be stored in the cold food bank. **McCall Refrigerator Corp., Hudson, N.Y.**

For more details circle #473 on mailing card.

Packaged Incinerator Handles Pathological Waste

The new packaged Brulé Model M-10 All-Purpose Incinerator with HY-FA is designed with two rear chambers beyond the firing chamber. Here smoke, soot, odors, embers and sparks are incinerated and fly particles are centrifuged out. It is designed to incinerate all types of waste; dry, intermixed or wet, with clean operation within a wide diversity of local conditions. Pathological waste, surgical and maternity waste and tuberculosis waste, when in minor amounts, can be readily consumed with other hospital waste in the model M-10. The modified Brulé M-10 should be used for intensive charges of these wastes. This pathological incinerator has internal modifications for clear sterile ash production.

The Model M-10 is prefabricated, lined throughout with high temperature insulating refractory, lined vent parts, dampers, burners and other equipment required for local installation. The component parts can be assembled and bolted for operation on the job. Sizes to handle all requirement are available. **Brulé Incinerator Corp., 407 S. Dearborn St., Chicago 5.**

For more details circle #474 on mailing card.

Fing-R-Gard Edge for Entrance Doors

A newly developed flexible vinyl plastic edge is now available for steel entrance doors. The Fing-R-Gard edge protects against crushed fingers when caught in a closing door. At the same time, it is completely weatherproof and seals out

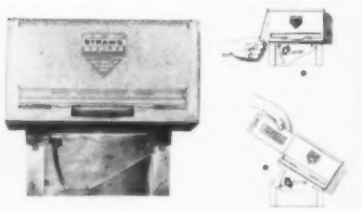
cold, heat and moisture. Formed in the shape of a "U", the Fing-R-Gard edge is attached as an integral part of the door. **Overly Mfg. Co., Greensburg, Pa.**

For more details circle #475 on mailing card.

WHAT'S NEW

Pre-Assembled Bracket for Duplex Dispensers

A new all-purpose bracket, pre-assembled and ready for mounting, is now



offered for Duplex Straw Dispensers. The dispensers can be easily attached to vending machines, mobile food trucks and walls with the new bracket. Duplex Straw Dispensers dispense unwrapped straws in all sizes and have approval of health boards according to the report by the manufacturer.

The dispenser is easily mounted to the bracket without the use of tools. With the stainless steel bracket, the Duplex Dispenser can be loaded with straws without being touched by human hands which assures complete sanitation. The new Duplex all-purpose bracket comes complete with hardware. **Duplex Straw Dispenser Co., Dept. 24, 511 N. La Cienega Blvd., Los Angeles 48, Calif.**

For more details circle #476 on mailing card.

Autoclave Ink Turns Green

The familiar traffic colors are used in the new Autoclave Ink introduced by Weck. Red when applied to packages, the ink turns green when it is autoclaved. The special ink is supplied in the Weck Autoclave Pencil containing leads of the ink in compressed form. It is also supplied with stamps and a special foam rubber stamp pad. Each set contains a combination rubber stamp with the wording, "Turns Green When Autoclaved" on the one side and an adjustable unit on the other. **Edward Weck & Company, Inc., 135 Johnson St., Brooklyn 1, N.Y.**

For more details circle #477 on mailing card.

Ceramic Tile Now In Large Size

The new Stylon Magna-Tile ceramic wall facing offers many construction advantages with its 12 by 16 inch large rectangular size. The wider expanse covered by one tile lowers installation time and requires less grouting. Magna-Tile is made frostproof for practical use outdoors as well as interior use. It is available in eight Matt-glazed colors and seven Ripple finishes. **Stylon Corp., Box 341, Milford, Mass.**

For more details circle #478 on mailing card.

Floor Machines for Heavy Duty Maintenance

The Tornado Series 90 heavy duty floor machines includes 14, 16 and 18-inch brush sizes to fill the individual need of any institution for heavy duty floor care. The series responds under the heaviest loads for scrubbing, stripping, polishing, steel wooling, sanding and terrazzo grinding. Features of the new machines include dual switch controls at the handle, under-handle cable connection and self-retracting, non-marking neoprene wheels

and vinyl bumpers around the edge of the housing to prevent scuffing of equipment. **Breuer Electric Mfg. Co., 5100 N. Ravenswood Ave., Chicago 40.**

For more details circle #479 on mailing card.

(Continued on page 238)

Hospital Slippers Fit Any Foot

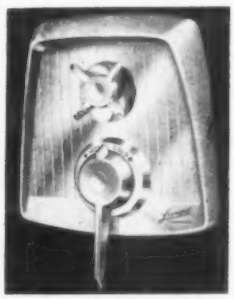
The new Allen-A Hospital Slippers are made of soft cotten knitted to a sup-

ple stretchable fabric which will fit any size foot. There are no rights or lefts and the style will fit both men and women. The knitting process gives extra strength and increases absorbency for added sanitation. The slippers are long wearing and are available in a blue and white striped pattern. **Allen-A Co., Div. of Atlas Underwear Co., Piqua, Ohio.**

For more details circle #480 on mailing card.

Volume Control in Showermaster Unit

The new Showermaster Control unit has a built-in volume control and shutoff. Encased in a modern chrome panel, it is a complete, self-contained thermostatic control for individual showers. The built-in volume control saves water and the bi-metal Dura-trol thermostat automatically compensates for temperature and pressure changes in either the hot or cold water supply, ensuring against sudden



changes. Safety stops limit the hot water temperature to 115 degrees F. maximum and selection of the desired volume will not affect temperatures.

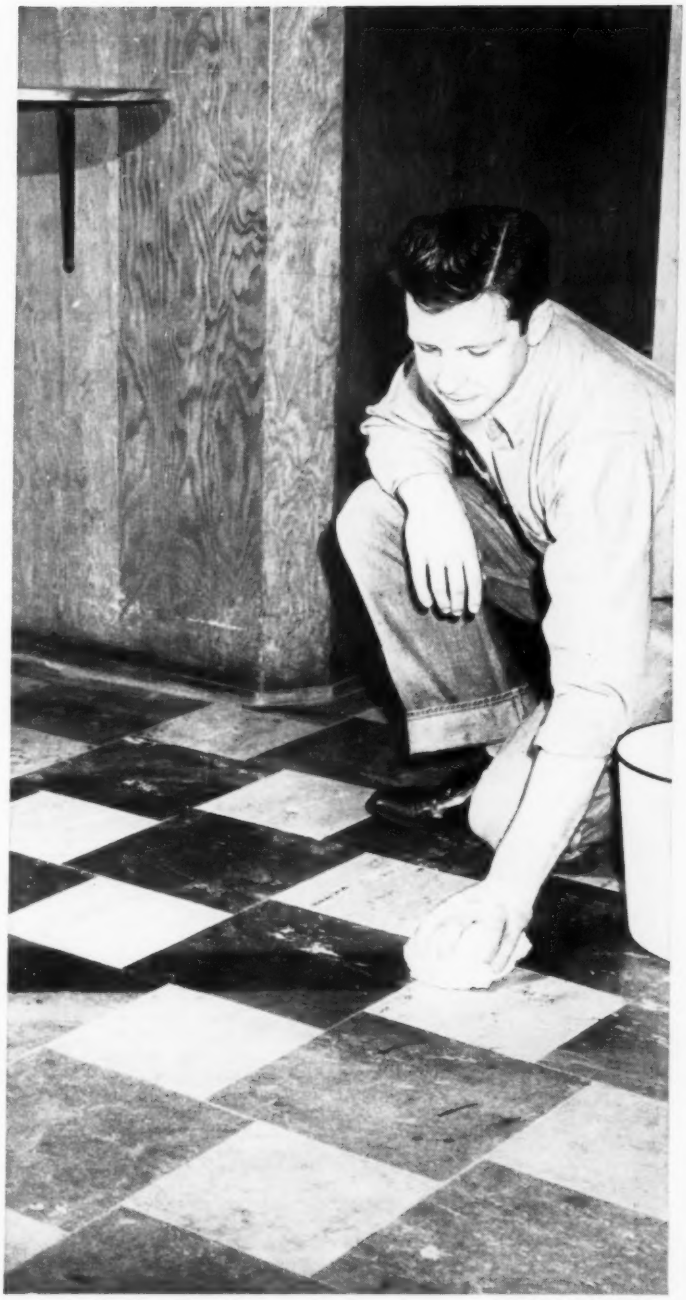
The Showermaster has only one moving part, which is self-cleaning, making it simple to install and maintain. No special skill or tools are required for servicing and the unit is constructed of high quality bronze. **Leonard Valve Co., Cranston 7, R.I.**

For more details circle #481 on mailing card.

(Continued on page 240)

Blue Blazes

Synthetic Cleaner now contains HCP!



BLUE BLAZES, the powerful synthetic cleaner, has been made *even more powerful* by the addition of HCP. The HCP ingredient activates BLUE BLAZES to provide *instantaneous penetrating action.*

How does it work? BLUE BLAZES, with HCP, immediately attacks dirt, oils, and any other foreign material that may be on the floor.

It penetrates grime, surrounds the particles, lifts them off the floor, and holds them in suspension until removed with a wet pickup vacuum, squeegee, or mop.

As gentle as rain water. It's completely safe, too. Though it overpowers dirt and grime in an instant, BLUE BLAZES with HCP is *chemically neutral* (pH of 7 in solution).

Non-Ionic. Because it is completely non-ionic, BLUE BLAZES with HCP is able to pick up both positively and negatively charged dirt particles. Also, it leaves no film or other residue which would help create static charges which attract and hold dirt particles to the floor.

Works in hard water or soft. BLUE BLAZES with HCP works in any kind of water . . . cold or hot, hard or soft. This makes it ideal for all phases of floor maintenance.

Because BLUE BLAZES is a free rinsing cleaner, no hard water scum or soap residue is left behind to dull the beauty of your floors.

You have to see it to believe it! Ask your local MULTI-CLEAN man to demonstrate how quickly BLUE BLAZES with HCP will clean your dirtiest floor. You'll be under no obligation whatsoever.

MULTI-CLEAN PRODUCTS, INC., Dept. MH-26-37
2277 Ford Parkway, St. Paul 1, Minnesota

☐ I'd like to see for myself what BLUE BLAZES with HCP can do for *my* floors. I understand demonstration will be free and I'll be under no obligation.

Send information on care of: ☐ Concrete, ☐ Wood, ☐ Asphalt Tile, ☐ Terrazzo, or ☐ _____ floors.

Name _____ Title _____

_____

Address _____

City _____ Zone ____ State _____

WHAT'S NEW

Fresh Citrus Fruit Sections Available in Gallon Jars

Fresh citrus fruit sections are now available in gallon jars for institutional

use. The fruit is packed principally in Florida and sent to local markets under refrigeration and is made available to institutions through local fruit broker or dairy. Varieties include orange, grapefruit, orange and grapefruit, and fruit salad which contains citrus fruits with pineapple, melon and maraschino cherries for color. Citrus fruit sections add taste variety to breakfast service, salads and desserts. **Florida Citrus Commission, Lakeland, Florida.**

For more details circle #482 on mailing card.

Cubi-Trac for Silent Curtain Movement

Cubicle curtains can be moved with practically no noise with the new ADC Cubi-Trac. Carrier wheels of sturdy polyethylene give practically noiseless curtain travel with long life. The cubicle track is of aluminum construction for lightness and each wheel is composed of a special non-wheel binding kralastic block. A special "bumper-to-bumper" feature prevents the wheels of one carrier from fouling with the next carrier. A rustproof swivel attachment assures free swinging movement of the carrier. The Cubi-Trac has 90 degree 12 inch radius curves with 12 inches of continuous, unspliced straight channel at each end. **ADC Cubicle Track Corp., Allentown, Pa.**

For more details circle #483 on mailing card.

Tracerlab Collimators for Clinical and Biological Use

Adapted from Oak Ridge models, the two new Tracerlab collimators are designed for clinical and biological use. The P-20BH Honeycone Focusing Collimator offers increased sensitivity through the larger combined aperture area and crystal size and lowered sensitivity to the axial position of activity at points other than the point of focus. The P-20BF Flat Field Collimator gives higher transmission with increased sensitivity. Both collimators are adapted for use with the Tracerlab P-20B Scintillation Detector or the Tracerlab RLD-2 Spectrometer Detector. **Tracerlab, Inc., 130 High St., Boston 10, Mass.**

For more details circle #484 on mailing card.

Wood Panels in Folding Door

A wood folding door of Beautywood is now offered at a budget price. Consisting of vertical panels of solid wood, Beautywood doors are connected with color fast, flame resistant, non-cracking Geon. Each panel is hinged with a series of pantagraph self-aligning, aluminum mounting units for smooth, even action. Floor guides and bottom tracks are not required with the new doors. Beautywood by Panelfold provides an attractive wood door when open and folds back

into minimum space. Doors are available for every standard sized opening. **Panelfold Doors, Inc., 1090 E. 17th St., Hialeah, Fla.**

For more details circle #485 on mailing card.

WHAT'S NEW

Microfilm Camera Films Both Sides Simultaneously

The new Remington Film-a-Record Model 11 duplex microfilm camera photographs both sides of a document at the same time at any of three reduction ratios. No special training is required to operate the unit as full operating controls, warning buzzer and indicator lights assure error-free microfilming. A single Colorstat control adjusts light intensity for proper recording of various types and colors of documents. The Film-a-Record holds 250 feet of 16 mm film which can be loaded in daylight. **Remington Rand, 315 Fourth Ave., New York 10.**

For more details circle #486 on mailing card.

Automatic Switchboard for Limited Needs

Hospitals and other institutions requiring only three to ten private telephones will be interested in the new Model 1B10 Dial Telephone Switchboard. The completely equipped unit provides top quality intercommunication service and requires only the addition of the telephones to be placed in operation. It will provide normal intercommunication as well as special features, such as paging, code number, speaker phone and other services. **Telecom Inc., 1019 Admiral Blvd., Kansas City 6, Mo.**

For more details circle #487 on mailing card.

U. L. Listed Exit Lights Have One-Piece Steel Frame

One-piece body frames of fused steel are a feature of the new line of U.L. listed recessed and surface-type exit lights. All units are finished with a rustproof neutral tone aluminum bronze which resists dirt and dust. Baked white Fluracite enamel is used for the interior reflecting surfaces for maximum illumination. Added illumination over the point of exit is provided in the surface-type units with glass bottom panels.

The new line also features an upward opening door to eliminate fumbling and groping during maintenance and relamping. Exit lights are available in 198 varieties to meet all local codes. **Curtis Lighting, Inc., 6135 W. 65th St., Chicago 38.**

For more details circle #488 on mailing card.

(Continued on page 242)

Locker Rack Takes Minimum Space

Where clothes storage floor space is limited, the Lyon Locker Rack provides a convenient and practical solution. Accommodating 10 persons, the rack is 50 inches wide, 18 inches deep and 76 inches high with all compartments at a convenient level. Coats and jackets can be locked to the rack by a hanger and chain arrangement and each door is equipped with a built-in lock with two keys. The rack is portable and can be

easily moved to any place of need. It is finished in gray baked-on enamel. **Lyon Metal Products, Inc., 2931 Madison St., Aurora, Ill.**

For more details circle #489 on mailing card.

Acoustical Units Have Aluminum Face

Hansotex is a new acoustical ceiling treatment with aluminum face and pre-selected sound absorbing element. It is

low in cost, incombustible, has high acoustical value and is decorative. The pre-selected sound absorbing element is permanently bonded to the aluminum and the embossed pattern of the face has openings slanted in depth. The flat aluminum surface of Hansotex is finished in glare-free baked enamel for easy maintenance.

Installation is inexpensive, as the two by two foot units are simply placed on exposed Tee-runners or Zee-runners. They are removable for easy access to the plenum. They can be adjusted any time after installation to fit changing layouts and modified utilities and will accommodate to most types of lighting, air conditioning and partitioning. **Elof Hansson, Inc., Acoustical Div., 711 Third Ave., New York 17.**

For more details circle #490 on mailing card.

Electric Plaster Groover Picks Up Dust

The Wodack Electric Plaster Groover is designed for use in electrical work and in installing temperature control, central oxygen and other systems in existing buildings or new construction. The portable tool employs a six-inch abrasive cutting wheel which makes a single cut up to 1¾ inches in depth through plaster, lath, brick or concrete.

The feature of the new tool is a specially designed connection for attaching a commercial vacuum cleaner hose to

draw away all plaster dust. This development not only safeguards the health of the operator but keeps the air and floor free of plaster dust. **Wodack Electric Tool Corp., 4627 W. Huron, Chicago 44.**

For more details circle #491 on mailing card.

Anatomical Charts Assist Nurses

A set of 16 carefully prepared and printed Anatomical Charts has been developed by the Industrial Nurses' Section, Illinois State Nurses' Association, to assist in pinpointing areas of the body involved in or affected by injury or illness. The drawings are carefully done and the charts are printed by a two-color process for clarity and sharpness of detail. The charts are designed to assist the nurse in compiling concise, accurate medical-nursing records required in modern health service. **Illinois State Nurses' Assn., 6 N. Michigan Ave., Chicago 2.**

For more details circle #492 on mailing card.

Air Purifier Is Portable

A new air purification unit has been developed to serve any area in the hospital where odors, gases, vapors or stuffiness need be eliminated. The lightweight cylinder type unit is fitted with a

wrought iron stand for easy carrying from room to room. The purifier employs a purification system using activated charcoal and is especially applicable for autopsy rooms, cafeterias, cancer rooms, examination, operating recovery rooms, and toilets. **Barnebey-Cheney Co., Pure Air Div., Eight & Cassady Aves., Columbus 3, Ohio.**

For more details circle #493 on mailing card.

Removable Heating Element for Water Stills

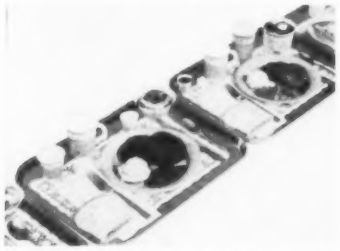
The heater block on electrically heated water stills can be easily removed due to the new side mounting heating element panel. It can be removed without disconnecting existing piping or otherwise dismantling the still. The panel is taken out for easy replacement of the separate elements or for cleaning the evaporator, by the removal of four bolts. The horizontally mounted elements give maximum steam disengaging space and high quality water. **Consolidated Machine Corp., 39 Sudbury St., Boston 14, Mass.**

For more details circle #494 on mailing card.

WHAT'S NEW

Eighteen Items in Matched Food Service

The new Dixie Matched Food Service for institutions features eighteen colorful



items in paper. Included are plastic-coated and uncoated plates sturdy enough to withstand cutting of meat and to resist absorption; cream and condiment cups in three sizes; cold drink cups in three sizes; food dishes in two sizes; food containers; plastic-coated hot drink cups with handles in two sizes, and a cone-shaped cup for milk.

Advantages claimed for use of the new matched service include elimination of breakage, quiet food service, quick clean-up with savings in time and dish-washing, minimum storage space and lightweight. The service is offered in a pleasing pastel green and is completely disposable. **Dixie Cup Co., Easton, Pa.**

For more details circle #495 on mailing card.

Hot, Fresh Food From New Appliance

The Fresh-O-Matic by Wear-Ever is a new kind of appliance which heats and freshens baked goods, meats and other foods in three seconds, yet occupies little more work area than a square foot. Cold food is placed on an easy-to-remove tray in the appliance, the cover closed and a handle pressed down. The Fresh-O-Matic pumps tiny jets of dry steam which penetrates foods in seconds thus making a variety of hot dishes available in a short amount of time.

The new appliance also steams clams, poaches eggs, cooks lobster and barbecues spare-ribs. The exterior of the Fresh-O-Matic is textured aluminum. **The Aluminum Cooking Utensil Co., Inc., H & I Div., New Kensington, Pa.**

For more details circle #496 on mailing card.

Specialist Projector for Filmstrips and Slides

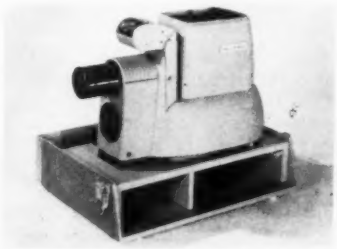
Bright, uniform pictures and extremely low film plane temperatures when operated out of the case are features of the new 500-watt Specialist Projector. When used in the airflow case, a special system reduces temperatures further. The projector is adapted for use with single and double-frame filmstrips and two by two slides. The special cooling devices protect

(Continued on page 244)

slides and film against color fading, warping and drying.

Ceramic tracks protect filmstrips used in the projector. A built-in take-up compartment rolls the film as it is used. The change from single to double frame filmstrips is accomplished by simple sliding plates. Filmstrips may be projected either vertically or horizontally and even spliced or bent strips will be accepted. A manual two by two inch slide changer is standard.

Two locking clips hold the projector firmly in the case and the tilt mechanism has a locking device. The Specialist is made of sturdy, die-cast aluminum, finished in silver-gray. Clear-cut operating instructions and a sketch of the film



patch are permanently mounted on a plate on the side of the unit for ready reference. **Bell & Howell Co., 7100 McCormick Rd., Chicago 45.**

For more details circle #497 on mailing card.

WHAT'S NEW

Stainless Steel Fountains at Economical Prices

The newly designed line of Elkay stainless steel drinking fountains com-

bines economical price with fine fabrication and workmanship. A new embossing around the bubbler drilling keeps plumbing rough-in completely above the water level line and allows the fountains to meet rigid sanitary codes. Models available include a fully recessed fountain, a semi-recessed model, illustrated, and a fully exposed unit. A wide back on the recessed models gives ample head room. A large removable access panel is incorporated into the semi-recessed and fully exposed units. **Elkay Mfg. Co., 1874 S. 54th Ave., Chicago 50.**

For more details circle #498 on mailing card.

Sink Unit Has Glass Washers

A new three compartment sink unit features two glass washers with a one-operator capacity of 1800 glasses per hour. Known as the Model 2400 Twin-Lusterizer glass washer, the units may be operated together or separately and will handle any size glass from one to 16 ounces. The washers incorporate a waterproof, shockproof motor; forced water spray which reaches inside and outside of the glass, and a combination of neoprene fins and nylon brushes for

stubborn deposits. An on-off push button control for each washer operates by hand or knee. **Olson Products Corp., 3020 Central Ave., Indianapolis 5, Ind.**

For more details circle #499 on mailing card.

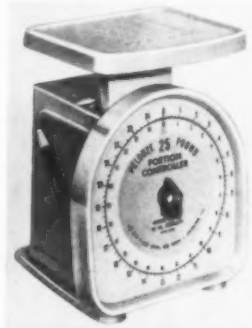
Black Spirit Carbon for Direct Process Duplicators

Ditto's new Black Hi-Gloss carbon produces 100 and more black-on-white copies on any spirit duplicator, using regular duplicator fluid. Preparation of masters is the same as for conventional purple spirit carbon. Paper and hands stay clean as the carbon surfaces and edges are chemically treated to prevent staining or smudging. Hi-Gloss is available in 8½ by 11 and 8½ by 14 inch sizes in single carbon sheets or in Masterset form. **Ditto, Inc., 6800 N. McCormick Rd., Chicago 45.**

For more details circle #500 on mailing card.

Portion Control Scale for Food Service

Developed to facilitate portion control in quantity feeding, the new Pelouze Portion Control Scale weighs up to 25 pounds. It is designed to determine net weight of foods for large quantity recipes



in any institution. The rotating dial permits easy determination of net weight of ingredients, minus pan or kettle, thus simplifying the weighing of more than one ingredient. The dial is set at "0" after each product is weighed, minimizing the possibility of errors and eliminating the necessity of adding totals.

Figures are sealed between two layers of laminated plastic to prevent scratching and damage. The dial can be marked with a colored wax pencil and the baked-on white enamel finish is easy to clean. The scale has an all steel case and stands 8½ inches high. **Pelouze Mfg. Co., 1218 Chicago Ave., Evanston, Ill.**

For more details circle #501 on mailing card.

Coplin Staining Jar Has Non-Breakable Cap

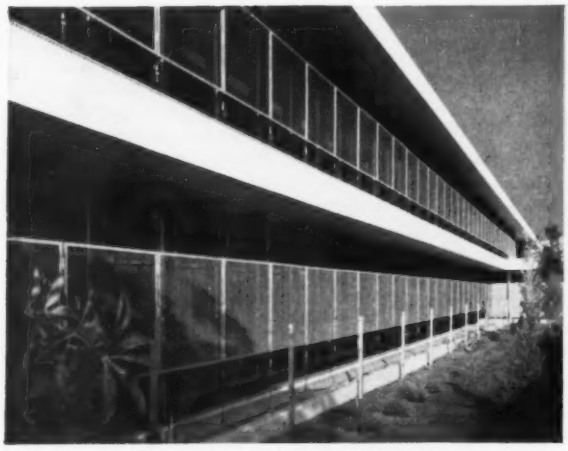
Among other improvements in the Coplin Staining Jar, it now has a non-breakable plastic cap. The specially designed closure utilizes G.C.A. standard, continuous screw thread for a positive seal when closed, to assure minimum evaporation. The cap has a cork-backed, foil liner that is impervious to organic solvents and all staining solutions. **Mercer Glass Works, Inc., 725 Broadway, New York 3.**

For more details circle #502 on mailing card.

(Continued on page 246)

A continuing series of outstanding office buildings, churches, schools, hospitals and industrial structures using **NORTON DOOR CLOSERS.**

Entrance side of administration building . . . note novel expanded metal "sunshade."



Roof overhang and panels of louvered screen reduce sun glare on south side.

15' Canopy held by structural planting trellises shades cafeteria entrance.

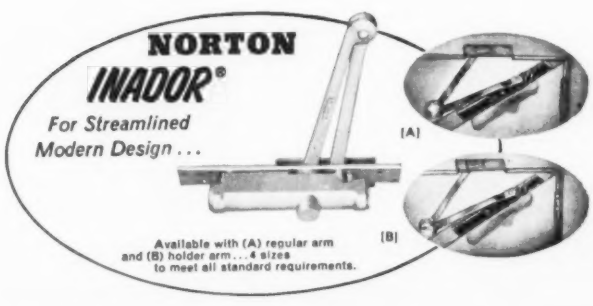
MODERN IN DESIGN . . . MODERN IN DOOR CLOSERS

NORTON INADORS® Installed in New Lockheed Headquarters

Matching the modern airplane in its dramatic clean-lined simplicity the new administration building of Lockheed Aircraft Service, Inc. at Ontario, California, incorporates many new concepts of design not common in the industrial field.

In complete harmony with these innovations are the Norton INADOR Door Closers used on interior doors. Their compact but powerful mechanism is fully concealed in a mortise in the top rail of each door so there is no compromise with harmony of design. They are, moreover, true liquid-type closers with all the reliability, low maintenance and precision workmanship which the name NORTON always implies.

Current catalog gives complete, illustrated data on all Norton models. Write for it today if you don't already have one.



A complete line of Norton Surface-type Closers is available for installations where concealment is not essential.

NORTON®
DOOR CLOSERS
Dept. MH37 • Berrien Springs, Michigan

WHAT'S NEW

Pharmaceuticals

Pen-Vee-Cidin

Pen-Vee-Cidin is a multiple action capsule specifically compounded for relief of the symptoms of the common cold and for the prevention of bacterial complications. It is especially useful in the treatment of those susceptible to upper respiratory infections. It is supplied in bottles of 36 capsules. **Wyeth Laboratories, 1401 Walnut Street, Philadelphia 2, Pa.**

For more details circle #503 on mailing card.

Moderil

Moderil is a new alkaloid of rauwolfia indicated as an anti-hypertensive and tranquilizing agent offering the advantages of Rauwolfia therapy with minimum sedative and bradycrotic effects. It acts by central depression of the sympathetic nervous system, without peripheral blocking, and does not affect cardiac output. The anti-hypertensive action is accompanied by a tranquilizing effect with a minimum of hypnosis. It is described as a safe, easily tolerated agent for long-term therapy, either alone or in combination with more potent agents. It is supplied in oval shaped, scored tablets in two potencies. **Pfizer Laboratories, Div. of Chas. Pfizer & Co., Inc., 630 Flushing Ave., Brooklyn 6, N.Y.**

For more details circle #504 on mailing card.

Parenzyme Aqueous

Parenzyme Aqueous is a new dosage form for administering the enzyme trypsin for reducing inflammation and swelling in a wide variety of disorders. It is supplied in 25 mg. vials which when placed in solution by adding 5 ml. of the accompanying diluent, provides 5 mg. of trypsin per ml. of solution. **The National Drug Co., Philadelphia 44, Pa.**

For more details circle #505 on mailing card.

Alba-Penicillin

Alba-Penicillin is a new combination of the antibiotics Albamycin and penicillin offering greater potency and broader range of activity than either component used alone. It is indicated primarily in mixed bacterial infections and those where organisms are resistant to the drugs separately or more sensitive to the combination. It is supplied in 16 capsule bottles. **The Upjohn Company, Kalamazoo, Mich.**

For more details circle #506 on mailing card.

Literature and Services

• **Bulletin No. 141** on the Barnstead MF Submicron Filter is now available from Barnstead Still & Demineralizer Co., 219 Lanesville Terrace, Jamaica Plain, Boston 31, Mass. Full information on this new development in pure water filtration is presented in the folder.

For more details circle #507 on mailing card.

• A third edition of **"A Manual of Blood Grouping and Rh Typing Serums"** has been edited by Hyland Laboratories, 4501 Colorado Blvd., Los Angeles 39, Calif. The booklet discusses the principles of blood grouping, blood typing and related laboratory procedures with recommended technics included.

For more details circle #508 on mailing card.

• Why the FMC Jet Disposer and Utensil Washer are practical for institutional kitchens is told in **Bulletin KB565, "Cost Savers for Every Busy Kitchen."** Construction diagrams and installation data are also included in this informative leaflet offered by Food Machinery & Chemical Corp., Kitchen Equipment Dept., 103 E. Maple St., Hoopeston, Ill.

For more details circle #509 on mailing card.

• A report on **Soviet Russia today** is presented in a paper bound book published by the National Cash Register Co., Dayton 9, Ohio. Profusely illustrated with photographs in color and black and white, the booklet tells the story of a recent tour of the Soviet Union. The informative publication presents interesting material on the Russian people, their cities, their living standard, their culture and religion, their stores and other subjects, as seen by an American business man on a visit.

For more details circle #510 on mailing card.

WHAT'S NEW

• **Spinco Model CP Continuous-Flow Paper Electrophoresis** is the subject of a new folder, **Form 4-CP,** prepared by Spinco Div., Beckman Instruments, Inc., Stanford Park Palo Alto, Calif. The function of the instrument, designed for preparing high-purity fractions in quantity, is detailed and illustrated.
For more details circle #511 on mailing card.

• The full product line manufactured by Waste King Corp., 3300 E. 50th St., Los Angeles 58, Calif. is described in a new catalog. Information on the **Waste King dishwasher, commecrial disposal line, gas and electric oven and range, and gas and electric incinerator** is contained in the booklet.
For more details circle #512 on mailing card.

• Complete specifications on the new line of **"All-Metal Commercial Refrigerators and Freezers"** manufactured by Victory Metal Mfg. Corp., Plymouth Meeting, Pa., are given in a new brochure recently released. The new line features interchangeable interiors with increased usable space and includes reach-in refrigerators, freezers, blood banks, biological or pharmaceutical, milk formula and other specially-designed refrigerators.
For more details circle #513 on mailing card.

• A 28-page booklet entitled **"For Better Health and Better Living"** is available from Merck & Co., Inc., Rahway, N. J. It describes the development of a discovery, progress through **research, engineering** for production and Merck service to the professions.
For more details circle #514 on mailing card.

• The Stenorette, a magnetic tape machine for dictation, recording of interviews, conferences, meetings and teaching, is described in a booklet, **"How to Use the Stenorette,"** issued by DeJur-Amsco Corp., 45-01 Northern Blvd., Long Island City, N. Y. The lightweight machine, made in Germany, has a number of interesting features described in the booklet.
For more details circle #515 on mailing card.

• Custom-built models of Trion packaged electronic air cleaners are described in complete detail in a catalog entitled **"New but Proved Super Clean Air"** released by Trion, Inc., 1000 Island Ave., McKees Rocks, Pa. **Catalog E-40** gives engineering data and size and capacity tables for fitting the proper model to the job.
For more details circle #516 on mailing card.

•National-U.S. Radiator Corp., Heating & Air Conditioning Div., Johnstown, Pa., offers two new catalogs describing new scotch-type steel boilers for oil or gas firing. **Catalog No. 819** details wet-back boilers with forced draft burners and **No. 820** describes natural draft type boilers.
For more details circle #517 on mailing card.
(Continued on page 248)

WHAT'S NEW

• All types of **Portable Sterilizers** are discussed in a new brochure issued by Shampaine Electric Co., 50 Webster Ave., New Rochelle, N.Y. Various models are illustrated and full details and specifications are included.

For more details circle #518 on mailing card.

• The 1957 catalog of **Halsey Taylor Drinking Fountains and Coolers** is now available from The Halsey Taylor Co., 137 North Ave., N.W., Warren, Ohio. The booklet discusses the complete line and includes dimensions and illustrations.

For more details circle #519 on mailing card.

• Prize-winning sandwich recipes are given in a new 20 page booklet issued by Standard Brands, Inc., Institutional Dept., 625 Madison Ave., New York 22. Entitled **"Four Star Sandwiches"** the booklet is designed for restaurant operators but should prove of interest to those responsible for menu planning in hospitals and other institutions.

For more details circle #520 on mailing card.

• **"First Aid for Fractures; Introduction"** and **"First Aid for Fractures: Skull, Spine and Pelvis,"** are the titles of two sound motion pictures recently released by the U.S. Navy for civilian use. They are available through United World Films, Inc., Government Dept., 1445 Park Ave., New York 29.

For more details circle #521 on mailing card.

• Information on **Blue Lake Green Beans** is offered to quantity food users by Associated Blue Lake Green Bean Canners, Inc., Portland 5, Ore. Included are operator-tested ideas and quantity recipes developed by users.

For more details circle #522 on mailing card.

• A new catalog entitled, **"Stran-Steel Buildings With the Luxury Look of Stran-Satin,"** announces the enlarged line of commercial steel buildings and accessories manufactured by Stran-Steel Corp., Ecorse, Detroit 29, Mich. Featured in the colorful brochure are the new rigid frame structures, two 50 and 60 foot bow string truss buildings and the recently developed Stran-Satin metal wall.

For more details circle #523 on mailing card.

• A 12-page brochure, **Edition 43,** on **"Ellison the Balanced Door"** is available from Ellison Bronze Co., Inc., Jamestown, N.Y. The simple door control mechanism is described and design possibilities are suggested through the use of photographs of installations.

For more details circle #524 on mailing card.

• A new engineering specification handbook on Lawler Thermostatic Control Valves is available from Lawler Automatic Controls, Inc., Mt. Vernon, N.Y. **Bulletin M-3** includes application information, graphs, diagrams and piping layouts.

For more details circle #525 on mailing card.

• Two new publications designed for the general practitioner will be issued monthly by Ciba Pharmaceutical Products, Inc., 556 Morris Ave., Summit, N.J. **"State of Mind"** will review emotional and psychiatric problems while **"Pulse & Pressure"** will report current views concerning hypertension and related cardiovascular disorders.

For more details circle #526 on mailing card.

• Information on the **"2200 3-in-1 Plugmold Electrified Baseboard"** is given in a new eight-page circular available from The Wiremold Co., Hartford 10, Conn. Known as Form 590, the folder illustrates and describes the wide application of 2200 Plugmold where multiple electrical outlets and additional circuits are needed.

For more details circle #527 on mailing card.

• Power-Pak packaged automatic boilers for steam or hot water heating and hot water service are described in **Bulletin No. 1233** issued by Orr & Sembower, Inc., Reading, Pa. Complete details are included on light oil firing, gas firing or alternative oil-fired units.

For more details circle #528 on mailing card.

• Information on the performance-economy and efficiency of air hand dryers is presented in a folder prepared by World Dryer Corp., 616 W. Adams St., Chicago 6. Included in the brochure are figures indicating the savings effected through use of the **high-speed dryers,** as well as names of users of the equipment.

For more details circle #529 on mailing card.

• The complete line of **Bennett Waste Receptacles** is illustrated and described in a new catalog issued by The Bennett Mfg. Co., Alden, N. Y. Complete specifications are given on the wide range of receptacles available in the Bennett line.

For more details circle #530 on mailing card.

Suppliers' News

L. E. Du Bach Industries, Post Office Box 472, Kansas City, Mo., announces that as of September 30, 1956 it is again the sole owner, and exclusive manufacturer and distributor of the Du Bach Surgical-Instrument Table, the Du Bach Scientific Over-bed Table with multiple uses, also eight new hospital items added to the line, developed by Miss L. E. Du Bach.

Levinthal Electronic Products, Inc., 2924 Fair Oaks Ave., Redwood City, Calif., manufacturer of electronic equipment, announces removal of all operations to **Stanford Industrial Park, Palo Alto, Calif.** Space in the new building will be devoted to research, development and manufacture of microwave radar and communication systems, medical electronic equipment and scintillation crystals.

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March, 1957

Please ask the manufacturers, indicated by the numbers I have circled, to send further literature and information provided there is no charge or obligation.

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547 American-
548 American
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550 Anemostat
551 Angelica
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553 Applegate
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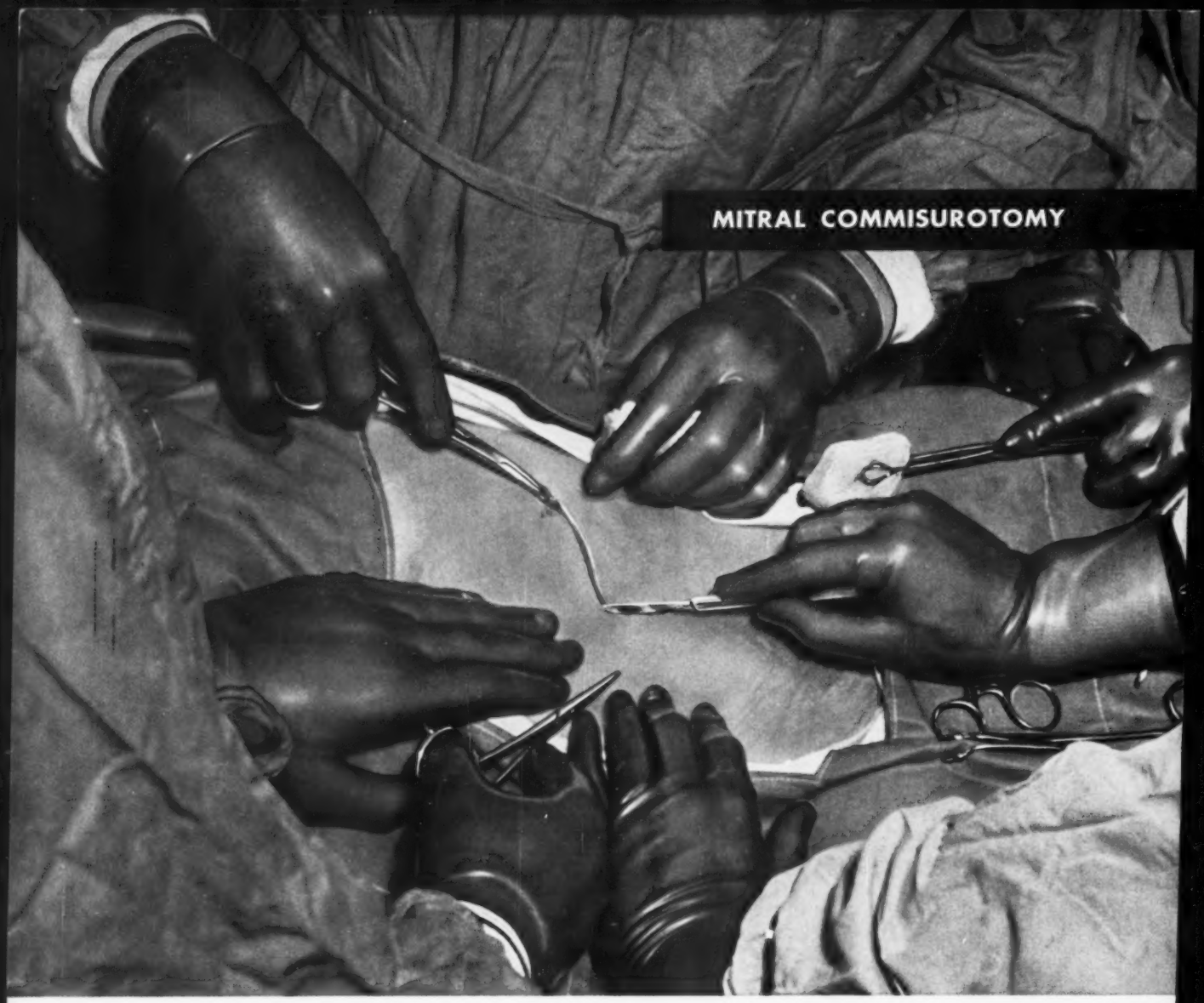

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